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THE HEALING POWER OF FAITH IN MOOD AND ANXIETY DISORDERS: A PASTORAL STUDY

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DEDICATED TO:
Those afflicted with depression and anxiety. May God bless you and keep you.

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ABSTRACT

THE HEALING POWER OF FAITH IN MOOD AND ANXIETY DISORDERS: A PASTORAL STUDY

The **central theoretical argument** of the study is that faith can heal or help counselees to cope with mood and anxiety disorders.

In the **meta-theoretical perspective** a **literature study** of recent research on mood and anxiety disorders and the therapeutic approaches to each within the disciplines of psychiatry, psychology, and medicine was done. It was found that there are a number of different causes and treatments for depression and anxiety with different disciplines emphasising different perspectives. An **empirical study** consisting of qualitative structured interviews and observations of a selected group of counselees struggling with depression and anxiety was also carried out. It was established that faith had played a significant role in the healing of the counselee's depression and anxiety or in their ability to deal with their illnesses.

The goal with the **basis-theoretical perspectives** was to explore what the Bible has to teach about "depression", faith and healing and to research the revelation historical stance on this. **Expositional studies** of a selected core of biblical references pertaining to depression were undertaken and key biblical figures who suffered from "depression" were studied. It was concluded that although the Bible does not speak of depression and anxiety *per se*, it describes people who might have been suffering from it. Valuable insights that can be used in helping counselees to deal and/or cope with their depression and anxiety were gained by studying these biblical characters and passages (2 Corinthians 1:3-11, Philippians 4:4-13 and Lamentations).

In the **practice-theoretical perspective** an integrative model which can be used by pastoral counsellors for dealing with depression in a faith-based context and

for equipping depression sufferers to constructively deal with their depression and anxiety was developed. This was accomplished by utilising the basis- and meta-theoretical perspectives in a hermeneutical interaction to formulate a **holistic faith-based model**.

KEY TERMS:

- Healing power
- Faith
- Mood and anxiety disorders
- Depression
- Pastoral

OPSOMMING

DIE HELENDE KRAG VAN GELOOF IN GEMOEDS- EN ANGSVERSTEURINGS

Die **sentrale teoretiese argument** van die studie is dat geloof kan genees of help in die heling van persone wat sukkel met gemoeds- en angsversteurings.

In die **metateoretiese perspektief** is 'n **literatuurstudie** gedoen oor die mees onlangse navorsing op die gebied van gemoeds- en gedragsversteurings en die terapeutiese benaderings tot elk binne die psigiatriese, psigologiese en mediese dissiplines. Bevindings is dat daar verskeie moontlike oorsake en behandelings beskikbaar is vir depressie en angs en dat elke dissipline fokus op 'n ander perspektief. 'n **Empiriese studie** bestaande uit kwalitatiewe, gestuktureerde onderhoude en observasies, is gedoen op 'n uitgesoekte groep wat sukkel met depressie en angs. Daar is bevind dat geloof 'n groot rol gespeel het in die heling van die beradenes se depressie en angs of in hulle vermoë om dit te hanteer.

Die doel met die **basisteoretiese perspektief** was om uit te vind wat die Bybel se leerstellinge is rondom "depressie", geloof en heling. **Eksposisionele studies** is gedoen van toepaslike skrifgedeeltes en van sekere Bybelse figure wat gesukkel het met "depressie". Daar is bevind dat hoewel die Bybel nie pertinent van depressie en angs praat nie, dit wel persone beskryf wat moontlik gesukkel het daarmee. Insiggewende resultate is bekom deur die studie van die Bybelse figure en skrifgedeeltes (2 Korintiërs 1:3-11, Filippense 4:4-13 en Klaagliedere) wat gebruik kan word om persone te help in die heling van en/of saamlewe met hulle depressie en angs.

In die **prakties-teoretiese perspektief** is 'n geïntegreerde model ontwikkel wat gebruik kan word deur beraders in die hantering van depressie in 'n geloofs-

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CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND AND PROBLEM STATEMENT

1.1.1 Background

Affect is the medical term for emotional state or mood; **affective disorders** are disorders of mood. The affective disorder that psychiatrists and psychologists call *depression* is characterised by a feeling that one's emotional state is no longer under one's control (Bear *et al.*, 2001:686).

Depression is a serious disease. Whether depression is felt mildly or acutely, temporarily or persistently, it strikes just about everyone, including Christians (SCB, 2001:464). The National Institute of Medical Health (NIMH), the world's leading mental health biomedical organisation, estimates that in South Africa 5,2% (2,3 million) out of a population of 44 million people suffer from depression (Anon, 2003). Depression is a worldwide problem. Uys and Middleton (2004:326) argue that depression is probably as common in Africa as in the Western World. The high unemployment and crime rates in South Africa, the Aids pandemic and increased alcohol and drug abuse are major contributors to feelings of hopelessness, despair, depression, anxiety, fear and emotional outbursts.

Emotions play an important part in depression. They impact on how one *feels*, *thinks* and *behaves*. God created people with emotions. Copeland (2002) points out that: "The capacity to feel and express emotions is a wonderful gift from God." God is also emotionally involved with people (Anon, 2002), and He shared with them the full range of human emotions (Jackson, 2002).

As a result of the fall of man in sin, emotions became self-directed and out of control. According to Meyer (1997:13) carnal, unredeemed emotions try to move people away from or out of the will of God. Only two things have ever

changed the human soul: the *fall* and *grace* – the power of Satan and the power of God (Crabb, 1997:6).

The derangement of emotions is what leads to the profound pain and much of the disability experienced in mental illness (NIMH, 2001) and often in depression. Considering the renewed awareness of the crucial role that depression plays in the lives of people, there is a serious need for additional research and understanding about depression and the role of faith in the emotional lives of people, especially those seeking counselling. Powlisen (2001:18) expresses the following about this need: "give us works that are theologically wise on the issue of emotions. Give us works rich in case-wisdom, in feel for human experience, in biblical depth."

Mitchell (2004:139) describes faith in God as the foundation block for emotional control, restoration and *healing*. God intervenes in the lives of people to bring about *healing*. The Lord promised that people would be "*filled with power*" when the Holy Spirit comes upon them. Jesus Christ would not have told His disciples that they were to go out in the world and proclaim the Gospel, *heal* the sick, cast out demons, and raise the dead (Matthew 10:80) if He did not expect them to do so with success.

Decisive action is required on the side of faith-based organisations, employers and counsellors to proactively address the suffering caused by depression.

1.1.2 Depression in general

Depression is a disorder of mood and thought (Bear *et al.*, 2001:19). Sadock and Sadock (2003:280) define *depression* as the psychopathological feeling of sadness.

According to Sue *et al.* (1994:174) *depression* is by far the most common mood disorder and is characterised by sadness, feelings of worthlessness and social withdrawal. *Mania* is characterised by elevated mood, expansiveness,

and irritability. *Depression* and *mania* are different from normal mood changes because they are more intense, last longer, and may occur for no apparent reason. Tan and Ortberg (2004:27) state that it is important to note that *clinical* depression as a psychological or psychiatric disorder is distinct from brief mood fluctuations or so-called normal depressions (i.e. those *feelings* of sadness, disappointment, and *frustration* that last from fleeting moments or minutes to, at most, a few days).

Minirth and Meier (2002:22) report that as psychiatrists they see more people suffering from depression than from all other emotional problems put together. Depression occurs most often in the fourth and fifth decades of life, but may occur during any stressful period from infancy to old age. Pent-up *anger* is the root cause of the vast majority of depressions. People who are suffering from serious clinical depression can find hope that there is a way out of the pain. Depression (without biological causes) is usually curable with the right kind of therapeutic help. Even depression caused by biological reasons, although not curable, can generally be managed with proper medication and counselling. Minirth and Meier are of the opinion that happiness can become a way of life if people **choose the right paths to obtain it** (Minirth & Meier, 2002:23).

One is led to conclude that much, if not all, of the judgements concerning aetiology, diagnosis, treatment and cure in the several related fields of psychology depend to a great extent upon the concept of emotion in the mind of the practitioner (Hillman, 1997:5).

1.1.3 The healing power of faith

Faith is the most important element in life – for without it, it is impossible to please God (Hebrews 11:6). Although faith has been given by God (cf. Philippians 3:12), it is also an act of trust by which people commit themselves to someone or something. Faith is believing, and believing is the object of people's trust (SCB, 2001:1634). Faith is also the key to getting one's prayers answered and the seeking of God's will.

People's salvation is "by grace ... through faith" (Ephesians 2:8). According to Anderson *et al.* (2000:105) one is saved by faith (see Ephesians 2:8) and sanctified by faith (see Galatians 3:3-5); people also walk, or live, by faith (see 2 Corinthians 5:7). God never bypasses the mind; rather, he works through it, transforming one by the renewing of the mind (see Romans 12:2). Smith (2002:9) explains that God is actively at work through the Holy Spirit in the life of the believer, renewing his mind and maturing his spirit, "till we all come to the unity of the faith and of the knowledge of the Son of God, to a perfect man, to the measure of the stature of the fullness of Christ" (Ephesians 4:13).

Although Jesus Christ never experienced depression, He experienced every emotion and suffered every feeling human beings do; He went through it, yet without sinning (Meyer, 1997:25). This is because He did not give in to His feelings. According to Bruno (2000:139) Jesus voiced and displayed His anger, for example, but then He always moved on to the good news of His kingdom, and focused on His kingdom. His heart was filled with love and truth; anger could not gain a permanent foothold in His life to poison Him. God's anger is therefore free from ill-temper (Sheperd, 1999). Jesus Christ did not give in to His feelings because He knew the Word of God in every area of life (Meyer, 1997:25).

Spiritual health is therefore absolutely necessary for all people to have psychological health. From this, one can conclude that a deep knowledge and understanding of the Word of God and growth in spiritual matters are required to deal with one's depression, because depression has an insidious way of draining energy, twisting values, and assaulting faith (SCB, 2001:464).

Seamands and Funk (1992:153), however, point out that depression is not necessarily a sign of spiritual failure. In the scriptural narratives, some of the greatest depressions came as emotional letdowns following the greatest spiritual successes – this was true in the life of Elijah (1 Kings 19:1-18), for instance. Our emotions should therefore always be submitted to wisdom (Meyer, 1997:15). The Bible teaches in the first chapter of Proverbs that one

is to operate in wise thoughtfulness. One is not to be led by one's feelings, but to be moved by them to show compassion and understanding towards those in need (see 2 Corinthians 1:4). Believers should let God, through His Word, also guide their emotions. This also applies to the depression sufferer. God's presence in people's emotional lives will gradually affect even their physical being (Anderson *et al.*, 2000:104) and the reality of life after death (cf. Romans 8:11) is evident when one walks by the Spirit, for the fruit of the Spirit includes love (the character of God), joy (the antithesis of **depression**), peace (the opposite of **anxiety**), patience (the antithesis of **anger**), self-control, and a number of other characteristics of a healthy, mature person (see Galatians 5:22-23). The connection between the initiating cause (the Spirit of truth working in people's lives) and the end result (love, joy, peace, patience, self-control) is the mind, which directs the brain, which in turn regulates all the glands and muscular movements (Anderson *et al.* 2000:104).

According to Minirth and Meier (2002:197) *faith* in Jesus Christ and in the principles of God's Word is at the root of all solutions (known and unknown), including those for depression. Belief in Christ is also a choice of the will (Minirth & Meier, 2002:136). To believe is simply to realise what Christ has done for us and to accept His death on the cross in our place for the punishment of our sins (Minirth & Meier, 2002:137).

According to Burkett (1998:129) God is merciful. He cares about the pain and suffering which people are experiencing, whether it is physical, mental, emotional, or spiritual. If people trust Him, He will give them peace. Koenig (1999:266) has shown by thorough research that religious people are shielded from depression and recover faster if afflicted than their less religious counterparts. Religion is also often a significant factor in preventing suicide, which is now threatening adolescents as well as adults.

Crabb (1997:32) believes that the surest route to overcoming problems and becoming the person one was meant to be is *reconnecting* with God and with the community of saints. He explains that this kind of relating depends entirely

on deep fellowship with Jesus Christ and then spills over to other people with the power to change their lives (Crabb, 1997:5). Struggles will continue, but they will be nudged out of the centre of one's life by the reality of meaning, joy, perseverance, and love (Crabb & Allender, 1996:205).

1.1.4 State of research on the healing power of faith in mood and *anxiety disorders*

After a thorough research on the different databases listed below, the following results on the topics which are being researched here have been found:

- The impact of faith-based initiative programmes in mental health: a model of programme development
  Database: UMI Proquest Digital Dissertations
- *Diskoerse oor heling binne 'n narratief-pastorale benadering* (Discourses on healing within a narrative-pastoral approach)
  Database: UPeTD
- Religious beliefs, faith community involvement and depression: a study on rural, low-income mothers
  Database: Sabinet Online – FS Article First
- When is faith enough? The effects of religious involvement on depression
  Database: Sabinet Online – FS Article First

Two of the studies have been done strictly on depression, and not necessarily on the *healing power of faith* within depression. The dimension of the healing power of faith has not been covered with regard to the encompassing topic of mood and anxiety disorders. It is therefore clear that the issue of the *healing power of faith and mood and anxiety disorders* has not thoroughly been researched and this study proposes to address the issue.

1.2 RESEARCH QUESTION

The discussion above on mood and anxiety disorders and the healing power of faith, leads to the following research question:

How can the healing power of faith be utilised by counselees to understand, manage and overcome mood and anxiety disorders?

The different research questions are:

- What are the scriptural perspectives and revelation-historical stance regarding "depression" and the healing power of faith?
- What perspectives do the Bible offer depression sufferers regarding their illness and their faith (as portrayed in selected passages related to "depression", such as Lamentations, and to the "depression" of key biblical figures, such as Moses, Job, Elijah, David and Jeremiah)?
- How do the scientific disciplines of psychiatry, psychology and medicine approach, contextualise, interpret and treat depression?
- How does a selected group of counselees experience depression and respond to faith-based counselling?
- How can a model be developed to help the pastoral counsellor contextualise depression and equip people with biblical knowledge and insights on faith to deal with their depression?

1.3 AIM AND OBJECTIVES

1.3.1 Aim:

The aim of this study is to research how the healing power of faith can be utilised by counselees to understand, manage and overcome mood and anxiety disorders.

1.3.2 Objectives:

The specific objectives of this research are:

- To explore what the Bible has to teach about "depression" and faith and to research its revelation-historical stance on this.
- To examine the answers offered to depression sufferers in holding on to faith by studying scriptural examples related to "depression", such as Lamentations, and of the harmful role that "depression" played in the lives of key biblical figures (such as Moses, Job, Elijah, David and Jeremiah), and to establish how they dealt with the "depression".
- To study the viewpoints of the scientific disciplines of psychiatry, psychology and medicine regarding depression and anxiety and the role these play in people's lives and how these conditions are treated.
- To examine how the selected group experience depression and respond to faith-based counselling by means of qualitative structured interviews.
- To propose an integrative model which can be used by pastoral counsellors for dealing with depression in a faith-based context and for equipping depression sufferers to constructively deal with their depression and anxiety.

1.4 CENTRAL THEORETICAL ARGUMENT

The central theoretical argument of this study is that the healing power of faith can be utilised by counselees to understand, manage and overcome mood and anxiety disorders.

1.5 METHOD

The method of Zerfass (cf. Heitink, 1999:113; Heyns and Pieterse, 1998:34-35), in terms of identifying basis-theoretical, meta-theoretical and practice-theoretical theories, will be employed. This method is employed in this study as follows:

i. **Basis-theoretical:**

Expositional studies of a selected core of biblical references pertaining to depression, such as 2 Corinthians 1:3-11, Philippians 4:4-13 and Lamentations, and by studying key biblical figures who suffered from "depression", such as Moses, Job, Elijah, David and Jeremiah. This will be done according to the grammatical-historical method (Pink, 1990:5). The basis-theoretical perspectives can be divided into two groups, namely the *expository perspectives* (as mentioned above), and a separate group that concentrates on *popular theological literature*. This will be discussed in a separate chapter.

ii. **Meta-theoretical:**

A **literature study** of recent research on depression and the therapeutic approach to depression within the disciplines of psychiatry, psychology, and medicine as well as an **empirical study**, i.e. qualitative structured interviews and observations of a selected group of counselees struggling with depression.

iii. **Practice-theoretical:**

The **basis** and **meta-theories** are used in a **hermeneutical interaction** to form a **practice-theory** and propose a **model** for the faith-based equipping of people to deal with depression.

1.6 CHAPTER OUTLINES

The meta-theoretical perspectives offer a description and outline (based on the different above-mentioned disciplines) of what mood and anxiety disorders entail and therefore provide the ideal point of departure for the study. Thus, the study will commence with the meta-theoretical perspectives and will then proceed to the basis-theoretical perspectives: the context will be discussed first, and then the text.

The content of the chapters of this thesis is as follows:

Chapter One:	Introduction
Chapter Two:	Meta-theoretical perspectives on the healing power of faith in mood and anxiety disorders
Chapter Three:	Basis-theoretical perspectives on the healing power of faith in mood and anxiety disorders: an expository approach
Chapter Four:	Basis-theoretical perspectives on the healing power of faith in mood and anxiety disorders: "popular theological approaches"
Chapter Five:	Practice-theoretical perspectives on the healing power of faith in mood and anxiety disorders
Chapter Six:	Final conclusions and suggested further research.

1.7 SCHEMATIC REPRESENTATION

This research may be schematically presented as follows in Table 1.1:

Problem Statement	Objectives	Method
How do the scientific disciplines of psychiatry, psychology and medicine interpret, contextualise and approach depression?	To study the viewpoints of the scientific disciplines of psychiatry, psychology, and medicine regarding depression and the role depression plays in people's lives and how it is treated.	A literature study of recent research on depression and the therapeutic approach to depression within the disciplines of psychiatry, psychology and medicine.
How does a selected group of counselees experience depression and respond to faith-based counselling?	To examine how the selected group experience depression and respond to faith-based counselling by means of qualitative structured interviews.	Qualitative structured interviews and observations in hermeneutical interaction with 1.5.ii.
What are the scriptural perspectives and revelation historical stance regarding depression and the healing power of faith?	To explore what the Bible has to teach about "depression" and faith and to research the revelation historical stance on this.	Expositional studies of a selected core of biblical references pertaining to depression and by studying key biblical figures who suffered from "depression", such as Moses, Job, Elijah, David and Jeremiah.

Problem Statement	Objectives	Method
		A study of different "popular theological approaches" as it pertains to depression and the healing power of faith.
What answers do the Bible offer depression sufferers regarding their illness and their faith (as portrayed in selected passages related to the "depression" of key biblical figures, such as Moses, Job, Elijah, David and Jeremiah?	To examine the answers offered to depression sufferers in holding on to faith by studying scriptural examples of the harmful role that "depression" played in the lives of key biblical figures (Moses, Job, Elijah, David and Jeremiah) and how they dealt with the depression.	
How can the pastoral counsellor contextualise depression and equip people with biblical knowledge and insights on faith to deal with their depression?	To propose an integrative model that can be used by pastoral counsellors for dealing with depression in a faith-based context and for equipping depression sufferers to deal with their depression.	The basis theory and meta theory are used in a hermeneutical interaction to form a practice theory and to propose a model for the faith-based equipping of people to deal with depression.

Table 1.1

CHAPTER TWO

META-THEORETICAL PERSPECTIVES ON THE HEALING POWER OF FAITH IN MOOD AND ANXIETY DISORDERS

2.1 OBJECTIVES

The objective of this chapter is to explain the viewpoints of the scientific disciplines of psychiatry, psychology and medicine regarding mood and anxiety disorders, specifically depression and anxiety, and the role these play in people's lives. The method of Zerfass (Zerfass, 1974:166; cf. Heitink, 1999:113; Heyns & Pieterse, 1998:34-37), in terms of identifying basis, meta, and practice theories will be employed. Meta-theory is concerned with drawing on the knowledge of other sciences in order to obtain a true picture of reality (Heyns & Pieterse, 1998:34). A secondary objective is to examine by means of qualitative empirical research how the experimental group experienced the healing power of faith in dealing with their psychopathology.

The meta-theoretical perspectives give a description and outline (based on the different above-mentioned disciplines) of what mood and anxiety disorders entail and therefore provide the ideal point of departure for the study. Thus, the study will commence with the meta-theoretical perspectives and will then proceed to the basis-theoretical perspectives.

2.2 INTRODUCTION

During the last century, practitioners of different clinical disciplines – psychiatry, psychology and social work – have risen to claim jurisdiction over matters of the *mind* (Whitaker, 1995). Increasingly, these disciplines are conceding that while they have much to offer, perhaps they have overreacted. *Normality* and mental health are central issues in psychiatric theory and practice but are difficult to define (Sadock & Sadock, 2003:16; cf. Brits, 2004a:44). For example, *normality* has been defined as *patterns of behaviour or personality traits that are typical or that conform to some standard of proper*

and acceptable ways of behaving and being. The use of terms such as *typical* or *acceptable*, however, has been criticised because they are ambiguous, involve value judgements, and vary from one culture to another (Sadock & Sadock, 2003:16).

According to Morris (1999:485) defining behaviour as *normal* or *abnormal* depends upon whose standards and system of values are used: the society's, the individual's or the mental health practitioner's (cf. Sadock & Sadock, 2003:17). The next table (Morris, 1999:486; cf. Joubert, 2005:197) shows that these three stakeholders have different viewpoints on mental health, and they consequently use different standards and measures in judging *normal* and *abnormal* behaviour:

Standards and measures of *normal* behaviour (Morris, 1999:486; cf. Joubert, 2005:197)

	STANDARD/VALUES	MEASURES
Society	Orderly world in which individuals assume responsibility for their assigned social roles (e.g. breadwinner, parent), conform to prevailing mores, and meet situational requirements.	Observations of behaviour, extent to which individual lives up to society's expectations and measures up to prevailing standards.
Individual	Happiness, gratification of needs.	Subjective perceptions of self-esteem, acceptance, and well-being.
Mental Health Practitioners	Sound personality structure characterised by growth, development, autonomy, environmental mastery, ability to cope with stress, adaptation.	Clinical judgement, aided by behavioural observations and psychological tests of such variables as self-concept, sense of identity, balance of psychic forces, unified outlook of life, resistance to stress, self-regulation, ability to cope with reality, absence of mental and behavioural symptoms, adequacy in love, work, and play, adequacy in interpersonal relations.

Table 2.1

For the purposes of this thesis, the viewpoints of the mental health practitioner (i.e. therapist or counsellor) will be the point of orientation from which psychopathology will be evaluated and diagnosed.

The need for a classification of *mental disorders* has been clear throughout the history of medicine, but there has been little agreement on which disorders

should be included and about the optimal method for their organisation (APA, 2000:xxiv). Because the various systems differed with respect to their emphasis and categorising of mental disorders, the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* was developed as a common international way of standardising mental disorders. Different revisions of the DSM had been published over the years, and the DSM-IV-TR is currently in use.

The section on *mood disorders* in the DSM-IV-TR includes disorders that involve a disturbance in *mood* as the predominant feature (APA, 2000:345). Mood disorders encompass a large group of disorders in which pathological mood and related disturbances dominate the clinical condition (Sadock & Sadock, 2003:534; cf. Nevid *et al.*, 2003:223; APA, 2000:345). According to Plutchik (2003:63), clinicians refer to mood disorders as those that involve some form of *depression* or its opposite, *mania*.

The *Diagnostic and Statistical Manual of Mental Disorders* or *DSM-IV-TR* (APA, 2000:20) identifies five major categories of *mood disorders*:

a. Depressive disorders
b. Bipolar disorders
c. Mood disorders due to a general medical condition
d. Substance-induced mood disorders
e. Mood disorders not otherwise specified.

Valfre (2001:241; cf. Brits, 2004b:30) offers the following classification of *mood disorders*:

Classification of mood disorders (Valfre, 2001:241; cf. Brits, 2004b:30)

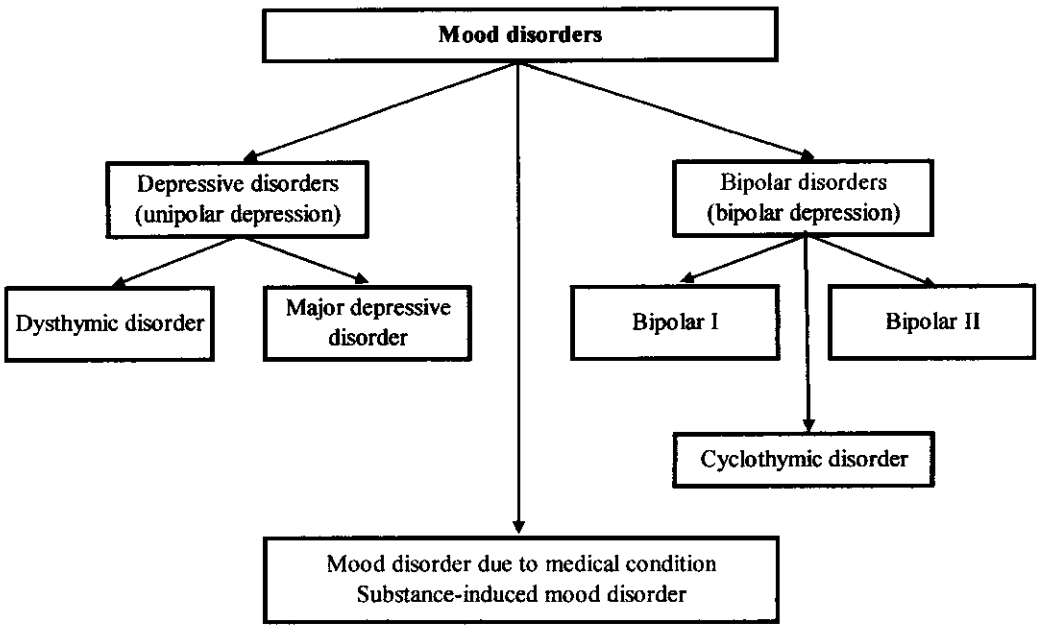


Figure 2.1

Sadock and Sadock (2003:281; cf. Plutchik, 2003:315) define *anxiety* as a feeling of apprehension caused by anticipation of danger, which may be internal or external. *Anxiety disorders* make up one of the most common groups of psychiatric disorders (ADAA, 2006; cf. Sadock & Sadock, 2003:593; Minirth and Meier, 2002:170). The following *anxiety disorders* are identified by the DSM-IV-TR (APA, 2000:21; cf. Plutchik, 2003:316; cf. Hart & Weber, 2005:169; cf. Strong, 2003:11-20):

a. Panic disorders
b. Phobias – social and specific
c. Obsessive-compulsive disorder
d. Posttraumatic stress disorder
e. Acute stress disorder
f. Generalised anxiety disorder
g. Anxiety disorder due to a general medical condition
h. Substance-induced anxiety disorder
i. Anxiety disorder not otherwise specified.

In 1994, the American Psychiatric Association elevated *religious and spiritual concerns* to a condition that could be addressed on Axis I in terms of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Whitaker (1995) argues that other disciplines require careful separation of *faith* issues from traditional value-neutral therapies, while at the same time requiring that these issues be addressed as part of a client's psycho-social history.

In the world of mental health care, where exact diagnosis dictates treatment, *anxiety* and *depression* are regarded as two distinct disorders. However, many people suffer from both conditions. In fact, most *mood disorders* present as a combination of anxiety and depression. Surveys show that 60-70% of those with depression also have anxiety (cf. Hart & Weber, 2005:169; Amen & Routh, 2003:7; Whitfield, 2003:15). Half of those with chronic anxiety also have clinically significant symptoms of depression (Marano, 2003; cf. Sadock & Sadock, 2003:600). The coexistence of anxiety and depression – called *comorbidity* in psychology – carries some noteworthy repercussions. It makes the course of the disorder more chronic, it impairs effective functioning at work and in relationships, and it substantially raises suicide risk. Over the past couple of years, clinicians and researchers alike have been moving towards a new conclusion: *depression* and *anxiety* are not two disorders that coexist; rather, they are *two* faces of *one* disorder (Marano, 2003; cf. Prinsloo, 1998:36).

For the purposes of this study, however, major depression as one type of *mood disorder*, and *anxiety disorders* as a whole – as they often go hand in hand with depression – will be the focus for this thesis. More specifically, the focus will be on how it pertains to the *healing power of faith*. *Depression* is a condition in which a person feels extreme sadness, withdraws socially, feels guilty and expresses self-deprecating thoughts (Jarvis & Middleton, 2004:319; cf. Sadock & Sadock, 2003:280; Plutchik, 2003:299). *Depression* occurs so frequently in the general population that it has been called the *common cold of psychiatry* (Solomon, 1998; cf. Burns, 2000:9; Tan & Lyles, 2005:146). Gilbert (2001:3) pointed out in 2001 already that it has been estimated that worldwide

over 300 million people may be suffering from depression. Depression has afflicted people for as long as records have been kept. Indeed, the famous ancient Greek doctor Hippocrates, who called it *melancholia* (cf. Biebel & Koenig, 2004:15; Brits, 2004b:31; Whitfield, 2003:9; cf. 3.3.1), first named it as a condition about 2 400 years ago. According to Gilbert (2001:3), it is also worth noting that although one cannot ask animals how they feel, it is likely that animals also have the capacity to feel depressed. Animals can certainly behave as if they are depressed. So, to a greater or lesser degree, all have the potential to become depressed, just as people all have the potential to become *anxious*, to grieve or fall in love.

Jarvis and Middleton (2004:319) maintain that significant levels of depressive symptoms are present in approximately 15-20% of the general South African population. They found that 30,6% of urban black adults and 15% of white, Asian and coloured adults suffer from clinical depression. *Depression* further accounts for approximately 75% of psychiatric hospitalisation in South Africa (Jarvis & Middleton, 2004:319). Kollar (1997:77) indicates that 75% of all cases of psychiatric hospitalisation are due to *depression* and indicates that only one in fifty depressed individuals in counselling are hospitalised.

Anxiety and *depression* are major public health problems that are reaching epidemic levels in the United States (Amen & Routh, 2003:1; cf. Sadock & Sadock, 2003:591; cf. Hart & Weber, 2005:162). According to the National Institute of Health (NIH), they affect 38 million Americans each year. Amen and Routh (2003:1) also point out that twice that number (75 million) will suffer from anxiety or depressive illness during some point in their lives. According to Bear *et al.* (2001:686; cf. Tan & Lyles, 2005:147; Meier, Clements *et al.*, 2005:122) major depression is the most common *mood disorder* in the USA, affecting 5% of the population in a year. A study released by the NIH estimates that 13-14 million Americans suffer from depression in any given year and that over 16% have depression at some point in life (TWA, 2006:171). Twenty percent have taken medicine for anxiety or depression

(Adler, 2006:45). Today, nearly four million American men are believed to suffer from depression (Guinto, 2005:78; cf. DFAQ, 2006).

Depression seems to be affecting more and more people. According to Tan and Ortberg (2004:17), people born during the past three decades are three to ten times more likely to become *depressed* than those born in previous generations. The suicide rate has been on a shocking increase in recent years, even among children and adolescents (Burns, 2000:9; cf. 2.6). This escalating death rate has occurred in spite of the billions of antidepressant drugs and tranquilisers that have been dispensed during the past several decades.

The pervasive interest in *faith healing* (cf. 3.3.3), the curative anecdotes of television evangelists, and the millions of hopeful individuals visiting religious shrines in search of relief give witness to the continuing interest in and prevalence of prayer and spirituality in the process of *healing* (Sadock & Sadock, 2003:865). According to Sadock and Sadock (2003:865), surveys indicate that 92 percent of a sample of inner city homeless woman reported one or more spiritual or religious practices. 48 percent reported that prayer was significantly related to reduced use of alcohol or street drugs or both and fewer perceived worries and *depression*. They further claim that epidemiological research indicates that religious beliefs and practices are negatively correlated with substance abuse and *positively* correlated with health status.

Depression and anxiety are complex conditions to handle or cope with. However, understanding these conditions is the first step toward effective coping.

2.3 PSYCHIATRICAL, PSYCHOLOGICAL AND MEDICAL PERSPECTIVES ON MOOD AND ANXIETY DISORDERS

The perspectives of psychiatry, psychology and medicine will be discussed interchangeably.

A psychiatric disorder is said to exist when mental or *emotional* symptoms become so severe that they interfere with a person's ability to function at work, at home, or in social relationships (Koenig, 2005:83). Interference with psychological, social or occupational functioning then, is the hallmark of a psychiatric disorder and is required to exist before a psychiatric disorder can be diagnosed (cf. Brits, 2004a:44).

According to Parker (2005; cf. Koenig, 2005:284), psychiatry is a branch of medicine that studies and treats mental and emotional disorders. Chaplin (1985:362) shows that psychiatry is the specialised branch of medicine dealing with the diagnosis, treatment, and prevention of mental disorders. Parker (2005; cf. Faw, 2004:12) describes psychology as the science dealing with the study of mental processes and behaviour in man and animals. According to Chaplin (1985:367), psychology is the science of human and animal behaviour; the study of the organism in all its variety and complexity as it responds to the flux and flow of the physical and social events that make up the environment. Koenig (2005:284), on the other hand, argues that the behavioural science of psychology may either be entirely academic (psychologists who teach and do research) or clinical (psychologists who do psychotherapy and/or psychometric testing). Psychiatrists, unlike psychologists, can also prescribe medication and take care of patients in a hospital (Koenig, 2005:284). Predominantly, however, psychiatrists prescribe psychotropic medication while psychologists conduct psychotherapy.

The following figure explains how psychotherapy takes place in practice. In order to explain the model, an imaginary patient, *Jane*, 45 years old, a recently divorced high school teacher and mother of two children (a boy of 14

and a girl of 12) will be used as an example of how this psychotherapeutic model can be applied (Joubert, 2005:217).

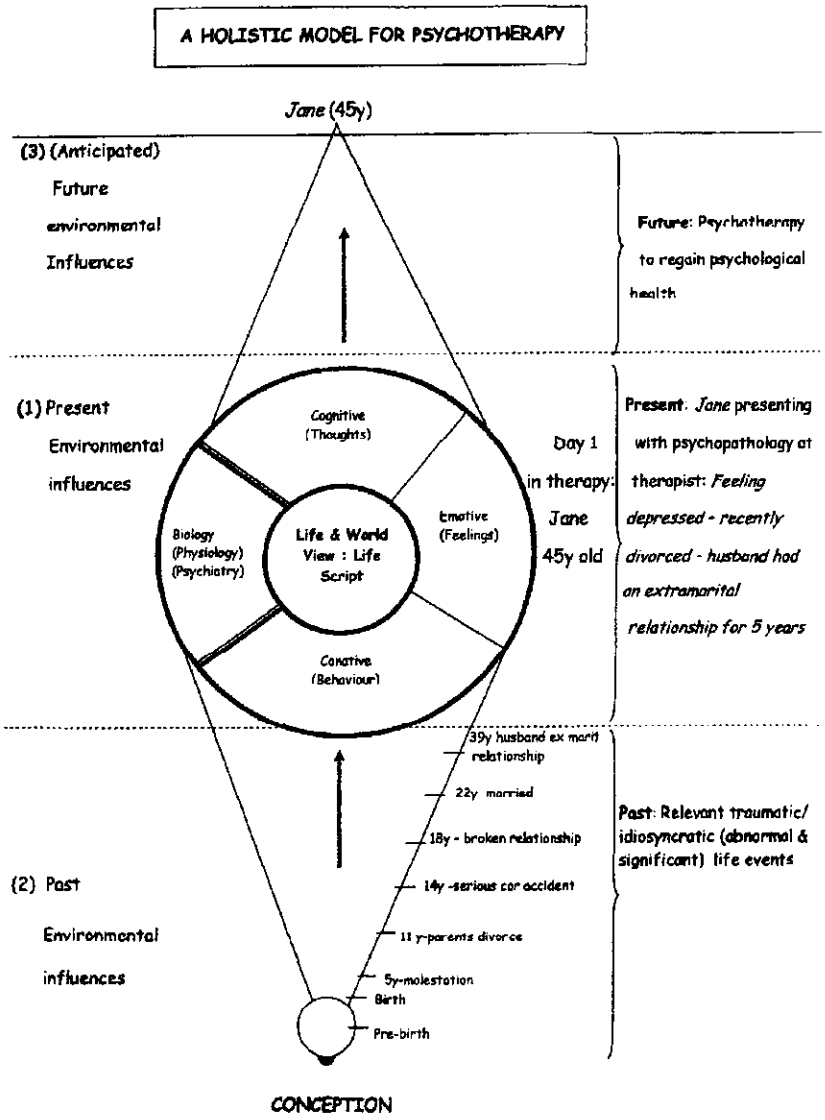


Figure 2.2

The psychotherapeutic model focuses on three time frames: the **present** (1), the **past** (2) and the **future** (3). Furthermore, there are different areas that need to be addressed during therapy: past and present abnormal/traumatic/idiosyncratic events that have had or are currently affecting the patient's psychological well-being must be addressed in therapy. The relative importance and value attached to such past and present events

and circumstances needs to be put into perspective. The cultural and socio-economic environment from which the patient comes and in which the patient is currently functioning has to be taken into consideration before therapy commences. Biographical information, such as level of education, age, marital status, etc. also needs to be taken into account in the formulation of a strategy for therapy (Joubert, 2005:218).

Thus, according to Joubert (2005:218), psychotherapy focuses on the following:

i. An analysis of present ailments/symptoms of a psychological nature that needs to be psychiatrically addressed (e.g. the prescription of mood stabilisers like antidepressants, etc.)
ii. Psychotherapy by a psychotherapist/psychologist/counsellor with specific focus on the following areas:
    - Present and past idiosyncratic life events and/or abnormal traumatic socio-economic environmental events
    - An evaluation of the patient's life script (i.e. world and life view)
    - An analysis of cognitive patterns
    - An analysis of emotional patterns
    - An analysis of behavioural patterns
    - Facilitating a future strategy (vision and goals for the patient) with the necessary coping skills to attain psychological wellness.

The author is of the opinion that this is a sound therapy model if counselling is approached from a purely psychological and or psychiatric angle. However, the model only focuses on psychological wellness, without consideration of the spiritual wellness of the client.

2.3.1 Defining depression

Written attempts to describe *depression* date back at least 4000 years (Tan & Ortberg, 2004:14; cf. Brits, 2004b:31). According to Gilbert (2001:3; cf. Plutchik, 2003:298), the term was first applied to a *mood* state in the seventeenth century. Tan and Ortberg (2004:14) recommend that the term *depression* must be thought of in a literal sense (to depress a lever, for instance) – it comes from the Latin *deprimere*, meaning to "press down" (Gilbert, 2001:3). To depress something is to move it from a higher level to a lower level. This movement from high to low captures much of the flavour of psychological *depression*, which involves a lower amount of energy, lower self-esteem, a lowering of mood, and in general a lowered appetite for life.

Depression is a disorder of *mood* and *thought* (Bear, *et al.*, 2001:19; cf. Gilbert, 2001:4). Mood is a mixed emotion of long duration subjectively experienced and reported by a patient and observed by others (Sadock & Sadock, 2003:280; cf. Plutchik, 2003:299). *Depression* is characterised by overwhelming feelings of dejection, worthlessness, and guilt (cf. Solomon, 1998). Sadock and Sadock (2003:280) describe depression as the psychopathological feeling of sadness. Plutchik (2003:308) claims that the function of sadness signals seems to be to elicit helpful behaviour from other people. Therefore, depression may be considered an extreme and persistent distress signal that continually seeks to solicit help from others.

Valfre (2001:408) emphasises another dimension, by describing *depression* as an *emotional* state characterised by feelings of sadness, disappointment, and despair. She explains that *depression* is a *whole body* illness that involves emotional, physical, intellectual, social, and spiritual problems (Valfre, 2001:250; cf. 2.2). Minirth and Meier (2002:25) show that depression is a devastating illness that affects the total being – physically, emotionally, and spiritually. The emotional pain of depression is more severe than the physical pain of a broken leg. Unlike a broken leg, however, the pains of depression come on much more gradually and last much longer. Many people are

suffering from numerous symptoms of depression without even realising that they suffer from depression rather than from some "purely physical illness". The symptoms of clinical depression fall into five major categories: sad affect, painful thinking, physical symptoms, anxiety, and for some, even delusional thinking (Minirth & Meier, 2002:26).

Uys and Middleton (2004:750; cf. Koenig, 1999:132) conclude that depression is a mood characterised by a feeling of sadness, dejection, despair, discouragement or hopelessness. They also find that depression is thought to be precipitated by a loss of some kind, real or imagined, such as self-esteem, a love object, independence, freedom, physical integrity, autonomy, youth, or material possessions.

Chaplin (1985:122) defines depression as follows: (1) In the normal individual, a state of despondency characterised by feelings of inadequacy, lowered activity, and pessimism about the future. (2) In pathological cases, an extreme state of unresponsiveness to stimuli, together with self-depreciation, delusions and inadequacy, and hopelessness.

From these definitions it can be concluded that depression is a mood characterised by feelings of dejection, worthlessness, sadness, despair, discouragement, despondency, inadequacy, pessimism, guilt and hopelessness. Depression affects the total being (physically, emotionally, socially, intellectually and spiritually), and therefore, as will be indicated in Chapter 5, a holistic approach to treatment is required.

2.3.2 Types of depression

Depression is not unitary or homogeneous. Tan and Ortberg (2004:27; cf. Gilbert, 2001:6; cf. Whitfield, 2003:13) argue that it is actually heterogeneous and refers to *different* types or kinds of depression with different risk factors involved.

Dr Archibald Hart has pointed out that because depression has many *types*, it is more correct to think of it as a "spectrum" disorder (cf. Tan & Ortberg, 2004:31; Meier, Clements *et al.*, 2005:123). However, despite its complexity, he notes that it is helpful to view depression as being one or a combination of the following three *things* or *meanings*: (1) it can be a *symptom* of something else (depression can be a side effect of a serious disease or influenza, for example); (2) it can be a *reaction* to life events like bereavement or losing a job (*reactive* depression); (3) it can be a *disease* or *disorder* in and of itself (when the body is suffering from some disorder of the biochemical system that disrupts psychic balance or equilibrium).

According to Tan and Ortberg (2004:27; cf. Sadock & Sadock, 2003:534; Plutchik, 2003:299) it is important to note that *clinical* depression as a psychological or psychiatric disorder is distinct from brief mood fluctuations or so-called normal depressions (i.e. those *feelings* of sadness, disappointment, and *frustration* that last from fleeting moments or minutes to, at most, a few days). Valfre (2001:241) explains that *mild depression* is short-lived and usually triggered by life events or situations outside the individual. For example, mild depression is common after suffering an important loss. Mild depression is usually self-limiting and subsides as interest in life returns to normal. People with mild depression can still function, but according to Cronkite (1999), they suffer from a chronically depressed mood, low self-esteem and low-level symptoms of depression. Mild depression may or may not have a triggering life event. Quite often there is nothing to blame it on – no loss or life change. Cronkite (1999) claims that this can be confusing for both the person affected and their loved ones. She has found that just as a person can catch a cold out of nowhere, one can also slip into mild depression for no apparent reason.

In contrast, *moderate depression* (dysthymia) persists over time. Valfre (2001:241), describes how feelings of depression begin to seriously interfere with activities of living, because individuals lack the energy to make it through the day. Persons with moderate levels of depression are at higher risk of

suicide as their depression increases. Depression that is diagnosed clinically is a more serious condition that lasts weeks to months, even possibly years (Tan & Ortberg, 2004:27).

2.3.2.1 Major depression or depressive disorder

The DSM-IV-TR (APA, 2000:375-376) lists the following diagnostic criteria for major depressive disorder, single and recurrent episodes:

	Major Depressive Disorder, Single Episode	**Major Depressive Disorder, Recurrent**
A.	Presence of a single major depressive episode.	Presence of two or more major depressive episodes. *Note*: To be considered separate episodes, there must be an interval of at least two consecutive months in which criteria are not met for a major depressive episode.
B.	The major depressive episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder not otherwise specified.	The major depressive episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder not otherwise specified.
C.	There has never been a manic episode, a mixed episode, or a hypomanic episode. *Note*: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.	There has never been a manic episode, a mixed episode, or a hypomanic episode. *Note*: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

	Major Depressive Disorder, Single Episode	Major Depressive Disorder, Recurrent
	If the full criteria are currently met for a major depressive episode, *specify* its current clinical status and/or features: Mild, moderate, severe without psychotropic features/severe with psychotropic features. Chronic. With catatonic features. With melancholic features. With atypical features. With postpartum onset.	If the full criteria are currently met for a major depressive episode, *specify* its current clinical status and/or features: Mild, moderate, severe without psychotropic features/severe with psychotropic features. Chronic. With catatonic features. With melancholic features. With atypical features. With postpartum onset.
	If the full criteria are not currently met for a major depressive episode, *specify* the current clinical status of the major depressive disorder or features of the most recent episode: In partial remission, in full remission. Chronic. With catatonic features. With melancholic features. With atypical features. With postpartum onset.	If the full criteria are not currently met for a major depressive episode, *specify* the current clinical status of the major depressive disorder or features of the most recent episode: In partial remission, in full remission. Chronic. With catatonic features. With melancholic features. With atypical features. With postpartum onset. *Specify*: Longitudinal course specifiers (with and without interepisode recovery). With seasonal pattern.

Table 2.2

In order for *major depressive disorder* to be diagnosed, one or more major depressive episodes must have occurred in the absence of a history of manic or hypomanic episodes (Nevid *et al.*, 2003:224). Tan and Ortberg (2004:29;

cf. Sadock & Sadock, 2003:542; Gilbert, 2001:6) interpret this as meaning that the depressed person must have experienced at least two weeks of depressed mood (or irritable mood in children or adolescents) or loss of interest or pleasure in almost all activities, together with a minimum of four other symptoms of depression (see 2.3.4), or only three if both depressed mood and loss of interest or pleasure occur (cf. Brits, 2004b:35). Symptoms such as changes in appetite; insomnia or excessive sleep; slowed movements or agitation; decreased energy or fatigue; feelings of worthlessness and excessive guilt; and indecisiveness or decreased ability to concentrate must occur almost every day (cf. Sadock & Sadock, 2003:534; Gilbert, 2001:6). Bear *et. al.* (2001:686) also list recurrent thoughts of death and suicide as a symptom.

Valfre (2001:241; cf. Nevid *et al.*, 2003:226) argues that severe depression encompasses one's whole being – every realm of human functioning. She further claims that persons with major depressive disorders have a high mortality rate and that up to 15% of individuals with severe major depressive disorder die by suicide (see 2.6). According to Bear, *et al.* (2001:687), episodes of major depression rarely last longer than two years. Burns (2000:9) indicates that one *can* overcome depression by learning some simple methods for mood elevation. Without treatment, however, depressions recur in 50% of cases, and after three or more episodes, the odds of recurrence increase to more than 70%.

A milder form of a depressive disorder is *dysthymic disorder.* According to the DSM-IV-TR the essential feature of dysthymic disorders is a chronically depressed mood that occurs for most of the day for more days than not for at least 2 years (APA, 2000:376). Tan and Ortberg (2004:30; also cf. Tan & Lyles, 2005:148; Sadock & Sadock, 2003:572) conclude that the depressive symptoms here are not serious enough to meet the criteria for major depressive disorder. Bear *et al.* (2001:687) claim that *dysthymia* has a chronic, "smoldering" course, and it seldom disappears spontaneously. According to Meier, Minirth *et al.* (1997:280), *dysthymia* is essentially the

depressive cycle of cyclothymia without the manic-like cycle. They argue that *dysthymia* is an extended form of *normal* depression.

The other category of depressive disorder is known as *depressive disorder not otherwise specified.*

2.3.2.2 Bipolar disorder

The DSM-IV-TR (APA, 2000:388 & 397) lists the following diagnostic criteria for bipolar I and bipolar II disorders:

	Bipolar I Disorder, Single manic episode		**Bipolar II Disorder**
A.	Presence of only one manic episode and no past major depressive episodes. *Note*: Recurrence is defined as either a change in polarity from depression or an interval of at least 2 months without manic symptoms.	A.	Presence (or history) of one or more major depressive episodes.
B.	The manic episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder not otherwise specified. *Specify* if: Mixed: if symptoms meet criteria for a mixed episode.	B.	Presence (or history) of at least one hypomanic episode.
	If the full criteria are currently met for a manic, mixed, or major depressive episode, *specify* its current clinical status and/or features:	C.	There has never been a manic episode or a mixed episode.

	Bipolar I Disorder, Single manic episode		**Bipolar II Disorder**
	Mild, moderate, severe without psychotropic features/severe with psychotropic features. With catatonic features. With postpartum onset.		
	If the full criteria are not currently met for a manic, mixed, or major depressive episode, *specify* the current clinical status of the bipolar I disorder or features of the most recent episode: In partial remission, in full remission. With catatonic features. With postpartum onset.	D.	The mood systems in criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder not otherwise specified.
		E.	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. *Specify*: current or most recent episode: *Hypomanic*: if currently (or most recently) in a hypomanic episode. *Depressed*: if currently (or most recently) in a major depressive episode.
			If the full criteria are currently met for a major depressive episode, *specify* its current clinical status and/or features: Mild, moderate, severe without psychotropic features/severe with psychotropic features. With catatonic features.

	Bipolar I Disorder, Single manic episode		Bipolar II Disorder
			With melancholic features. With atypical features. With postpartum onset.
			If the full criteria are not currently met for a hypomanic or major depressive episode, *specify* the clinical status of the bipolar II disorder and/or features of the most recent major depressive episode: In partial remission, in full remission. Chronic. With catatonic features. With melancholic features. With atypical features. With postpartum onset. *Specify*: Longitudinal course specifiers (with and without interepisode recovery). With seasonal pattern (applies only to the pattern of major depressive episodes). With rapid cycling.

Table 2.3

DSM-IV-TR (APA, 2000:20) lists four major types of bipolar disorder:

a. Bipolar I disorder
b. Bipolar II disorder (recurrent major depressive episodes with hypomanic episodes)
c. Cyclothymic disorder
d. Bipolar disorder not otherwise specified

Bipolar disorder is a very serious and under-recognised disorder that affects two to six percent of the population in the USA (Lyles, 2004; cf. Tan & Lyles, 2005:147). The hallmark of a *bipolar disorder*, according to Valfre (2001:242; cf. Gilbert, 2001:6), is sudden and dramatic shifts in emotional extremes. Persons with bipolar disorders live in a world that seesaws in cycles between emotional extremes of mania and depression. Valfre (2001:242; Tan & Lyles, 2005:148) explains that thoughts, moods and behaviours swing from normal to grandiose to depressed. Then a return to normal functioning follows, the "in-between time", before the cycle begins again. She points out that time intervals between manic episodes vary, and individuals who cycle rapidly have a poorer prognosis.

The word *mania* is derived from a French word for "crazed" or "frenzied" (Bear, *et al.*, 2001:687) and according to Valfre (2001:242; cf. Sadock & Sadock, 2003:534), *mania* is defined as an abnormally and persistently elevated, expansive, or irritable mood. During periods of mania, behaviours build in intensity as the individual move through three stages or levels of mania. *Hypomania*, an exaggerated sense of cheerfulness, begins the cycle (cf. Jarvis & Middleton, 2004:357). Soon cheerfulness progresses to the unstable "high" of *mania*. If allowed to continue, the extreme excitement of *delirium* may result (Valfre, 2001:242). During the manic phase, the individual's behaviours become more and more impaired (Valfre, 2001:242; cf. Nevid *et al.*, 2003: 231). If not treated, the manic phase of bipolar illness can last as long as 3 months. Eventually the depressive phase begins again. Hospitalisation is often required to break the cycle of mania and to protect the person from the negative consequences of poor judgments and actions (Valfre, 2001:242). The manic phase is characterised by common symptoms such as the following (Sadock & Sadock, 2003:535; cf. Bear, *et. al.*, 2001:687; Gilbert, 2001:6):

- Inflated self-esteem or grandiosity
- A decreased need of sleep
- Enormously energetic

- Great physical and mental activity
- Increased talkativeness or feelings of pressure to keep talking
- Flight of ideas or a subjective experience that thoughts are racing
- Distractibility
- Increased goal-directed activity
- Over-involvement in pleasurable activity
- Increased interest in sex.

According to Valfre (2001:242; cf. Tan & Lyles, 2005:148), *bipolar I disorder* is characterised by episodes of depression alternating with episodes of mania. She has found that it is the more severe and incapacitating form of bipolar illness. Tan and Ortberg (2004:30; cf. Sadock & Sadock, 2003:546) argue that in order for *bipolar I disorder* to be diagnosed, the following must be present:

1. One or more *manic episodes* in which the client feels hyper, extremely "high" wired, or unusually irritable, and gets into trouble, is unable to function at school or work, or ends up being hospitalised. Valfre (2001:242) concludes that delusions are common during periods of mania and, and hallucinations can occur
2. During the *manic episodes*, at least three of the following symptoms must be present: feeling overly self-confident or even grandiose; needing less sleep than usual; being unable to stop talking; having racing thoughts; being easily distracted; being much more active socially or sexually, or being much more productive at work or at school than usual, or feeling agitated much of the time; getting involved in pleasurable activities without thinking of the consequences (e.g., buying things that are not affordable or having unprotected sex with a stranger).
3. One or more *depressive episodes* as described earlier for *major depressive disorder*.

In order for *bipolar II disorder* to be diagnosed, the following must be present (Tan & Lyles, 2005:149; cf. Nevid *et al.*, 2003:231):

1. One or more depressive episodes as described for major depressive disorder.
2. One or more hypomanic episodes that are similar to manic episodes but are not as impairing or severe (Tan & Ortberg, 2004:31).

Valfre (2001:242) indicates that *bipolar II* disorder often results in 1 to 2 weeks of severe lethargy, withdrawal, and melancholy, followed by several days of elevated or irritable mood, constant activity, and risky decision making. Although the depths of depression and mania may not be as severe as with *bipolar I disorder*, the effects of *bipolar II disorder* are just as devastating (Valfre, 2001:242).

The extreme emotional swings of bipolar disorders are less intense in persons with *cyclothymic disorder* (Valfre, 2001:243; cf. Tan & Lyles, 2005:149). As the name implies, a *cyclothymic disorder* is a pattern that involves repeated mood swings alternating between hypomania and depressive symptoms. According to Sadock and Sadock (2003:576), cyclothymic disorder is symptomatically a mild form of bipolar II disorder. Zuckerman (2000:133; Sadock & Sadock, 2003:576) shows that *cyclothymia* runs a biphasic course, alternating manic and depressive patterns, often between the following:

- Pessimism, brooding – Optimism, carefree attitudes
- Unexplained tearfulness – Excessive punning, joking
- Lethargy, decreased speaking – Eutonia, talkativeness
- Hypersomnia – Decreased need for sleep
- Introversion, self-absorption – Uninhibited people-seeking
- Mental confusion, apathy – Sharpened and creative thinking
- Shaky self-esteem, low self-confidence – Grandiose overconfidence

- Unusually low productivity – Marked high productivity, unusual working hours

According to Valfre (2001:243) there are no periods of "normal" functioning for the person suffering from bipolar disorders. No day is free of symptoms because individuals bounce from "too high" to "too low". In order for *cyclothymic disorder* to be diagnosed, the following must be present:

1. Mood swings that are unpredictable, with the "ups" less severe than manic episodes and the "downs" less severe than major depressive episodes.
2. Reduced productivity and unreliability due to the unstable mood even though it does not cause significant problems per se (Tan & Ortberg, 2004:31; cf. Nevid *et al.*, 2003:233).

Many persons with *cyclothymic* problems eventually progress to full-blown (clinically definable) bipolar disorders (Valfre, 2001:243).

2.3.3 Causes of depression

There are a number of possible causes of depression, with various authors emphasising different causes depending on their theoretical viewpoints and models of depression (Tan & Lyles, 2005:149; cf. Nevid *et al.*, 2003:234; Solomon, 1998). Psychoanalytical theories see mood disorders as anger turned inward (cf. Solomon, 1998). Behaviourists view depression as a group of learned responses, whereas social theorists consider depression the result of faulty social interactions (Valfre, 2001:238; cf. Brown, 2004:87). According to Whitfield (2003:24), depression is often caused by or at least associated with having a history of situational causes, including childhood trauma.

According to Bear *et al.* (2001:687; cf. Gilbert, 2001:12; Plutchik, 2003:143; Sadock & Sadock, 2003:536) there is a *biological basis* for mood disorders. They are of the opinion that like most other mental illnesses, mood disorders

reflect the altered functioning of many parts of the brain at the same time: how else can one explain the coexistence of symptoms ranging from eating and sleeping disorders to loss of the ability to concentrate? For this reason, much attention has focused on the role of the diffuse modulatory systems, with their wide reach and diverse effects. In the past few years, however, disruption of the hypothalamic-pituitary-adrenal (HPA) system has also been implicated as playing an important role in depression.

The *neurobiology* of mood disorders are discussed below with reference to different hypotheses (Bear *et al.*, 2001:687-692; cf. Sadock & Sadock, 2003:536; Solomon, 1998):

- **The Monoamine Hypothesis**

The first real indication that depression may result from a problem with the central diffuse modulatory systems was made in the 1960's. The drug reserpine, introduced to control high blood pressure, caused psychotic depression in about 20% of patients. Reserpine depletes central catecholamines and serotonin by interfering with their loading into synaptic vesicles (cf. Zohar & Marshall, 2001:45). It was also discovered that another class of drugs introduced to treat tuberculosis caused a marked mood elevation. These drugs inhibit *monoamine oxidase (MAO),* the enzyme that destroys catecholamines and serotonin. Another piece of the puzzle fell into place when it was recognised that the drug imipramine, introduced some years earlier as an antidepressant, inhibits the reuptake of released serotonin and norepinephrine, thus promoting their action in the synaptic cleft. From these observations came the hypothesis that mood is closely tied to the levels of released "monoamine" neurotransmitters – norepinephrine and/or serotonin – in the brain (Brits, 2004b:14; cf. Coetzer, 2006:12). According to this theory, called the **monoamine hypothesis of mood disorders**, depression is a result of a deficit in one of these diffuse modulatory systems (cf. Plutchik, 2003:304; Zohar & Marshall, 2001:45; Valfre, 2001:238). Many of the modern drug treatments for depression have in common enhanced neurotransmission

at central serotonergic and/or noradrenergic synapses (cf. Zohar & Marshall, 2001:45).

Bear *et al.* (2001:689) stress that there are problems with a straightforward equation between mood and modulator. Perhaps most striking is the clinical finding that the antidepressant action of all these drugs takes several weeks to develop, even though they have almost immediate effects on transmission at the modulatory synapses. Another concern is that other drugs that raise norepinephrine levels in the synaptic cleft, such as cocaine, are not effective as antidepressants. A new hypothesis is that the effective drugs promote long-term adaptive changes in the brain that alleviate the depression. One adaptation occurs in the HPA axis, which has also been implicated in mood disorders.

- **The Diathesis-Stress Hypothesis**

According to Bear *et al.* (2001:689; cf. Nevid *et al.*, 2003:247), there is clear evidence that mood disorders run in families and that one's genes predispose one to this type of mental illness. The medical term for predisposition for a certain disease is *diathesis*. However, it has been established that early childhood abuse or neglect and life stresses are also important risk factors in the development of mood disorders in adults. In an attempt to bring these findings together, Charles Nemeroff and his colleagues at Emory University have proposed the **diathesis-stress hypothesis of mood disorders**. According to this new idea, the HPA axis is the main site where genetic and environmental influences converge to cause mood disorders.

Exaggerated activity of the HPA system is associated with anxiety disorders (Bear *et al.* (2001:690). However, anxiety and depression often coexist; in fact, this comorbidity is the rule rather than the exception (cf. Sadock & Sadock, 2003:552; Amen & Routh, 2003:8). Blood cortisol levels are elevated, as is the concentration of cortisol releasing hormone (CRH) in the cerebrospinal fluid, raising the question as to whether this hyperactive HPA

system, with its resulting deleterious effects on brain function, could be the *cause* of depression. Animal studies are highly suggestive of this. Injection of CRH into the brains of animals produces behavioural effects that are reminiscent of major depression: insomnia, decreased appetite, decreased interest in sex, and, of course, an increased behavioural expression of anxiety.

According to Bear *et al.* (2001:692), the activation of the hippocampal glucocorticoid receptors by cortisol normally leads to feedback inhibition of the HPA axis. In depressed patients, this feedback is disrupted, explaining why HPA function is hyperactive. A molecular basis for the diminished hippocampal response to cortisol is a decreased number of glucocorticoid receptors. In a fascinating parallel with the factors implicated in mood disorders, genes, monoamines, and early childhood experience regulate the glucocorticoid receptor number.

Glucocorticoid receptors, like all proteins, are the product of gene expression (Bear *et al.*, 2001:692). It has been shown in rats that early sensory experience regulates the amount of glucocorticoid receptor gene expression. Rats that received a lot of maternal care as pups express more glucocorticoid receptors in their hippocampus, less CRH in their hypothalamus, and reduced anxiety as adults. The maternal influence can be replaced by increasing the tactile stimulation of the pups. Tactile stimulation activates the ascending serotonergic inputs to the hippocampus, and the serotonin triggers a long-lasting increase in the expression of the glucocorticoid receptor gene. More glucocorticoid receptors make the animal better at "handling" stress as adults. The beneficial affect of experience, however, is restricted to a critical period of early postnatal life; stimulation of the rats as adults does not have the same effect.

Childhood abuse and neglect, in addition to genetic factors, are known to put people at risk for developing mood and anxiety disorders, and these animal findings suggest one cause (cf. Murray & Fortinbury, 2004:11). Elevations in

brain CRH and decreased feedback inhibition of the HPA system may make the brain especially vulnerable to depression (Bear *et al.*, 2001:692).

Nevid *et al.* (2003:248) gives the following representation of the diathesis-stress model for depression:

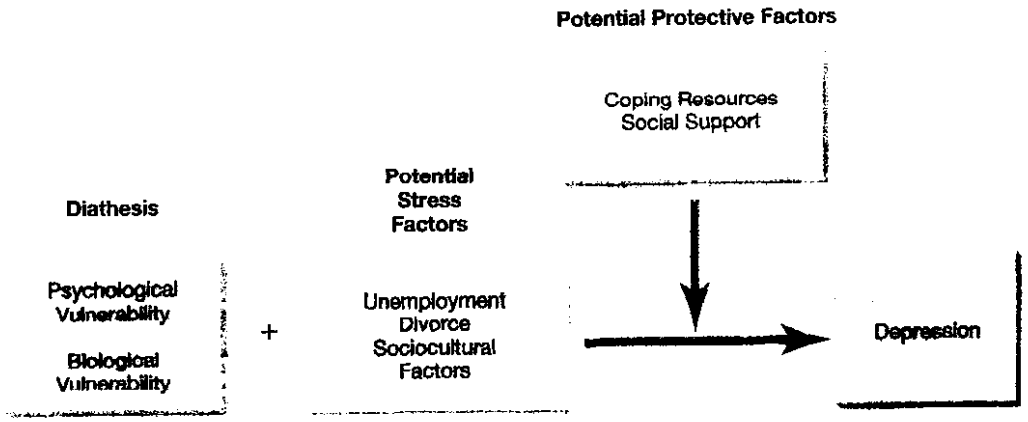


Figure 2.3

Tan and Ortberg (2004:32-39) list the major possible causes of depression as the following:

a. *Physical factors*

Lack of sleep, lack of regular exercise, poor diet or nutrition, overwork or exhaustion, or some types of physical illness/condition (i.e. hypothyroidism, stroke, a heart attack, cancer, Parkinson's disease, and hormonal disorders) can contribute to depression (cf. Plutchik, 2003:304; Leventhal & Patrick-Miller, 2004:530; Brits, 2004b:33; DFAQ, 2006). Postnatal depression and winter depression (SAD) are specific examples of how physical or biological factors can lead to depression.

b. *Temperament vulnerability ("depression-prone personality")*

Some people are more susceptible or prone to depression, and may therefore need to take special steps to avoid potential *depression-producing* situations or relationships.

c. *Sin*

There are times and occasions when depression may be a consequence of sin in a person's life, but this does *not* mean that all depression is always due to personal sin. Tan and Ortberg (2004:34) point out that some examples of possible sinful causes of depression include negative, sinful attitudes or feelings like bitterness, resentment, or hatred; guilt and unrepentance over present sinful behaviour or attitudes; backsliding or turning away from the Lord and his Word; fear of the future and lack of trust in God as sufficient provider; and unbelief in general (cf. Tan & Lyles, 2005:150; Faw, 2004:152; cf. 3.3.1, 3.3.4).

d. *God-sent trials*

Difficult, painful, stressful times of trial or struggle may lead to periods of depression. God's love does not mean that all our thoughts, emotions, and behaviours will be pleasant and pure (McGee, 2003:3). Tan and Ortberg (2004:34) express the opinion that such God-sent trials are meant to prune or purify a person, so that they can bear more fruit (John 15:2; 1 Peter 1:6-7).

e. *Demonic attacks*

Satan and his demonic forces can attack and oppress people, making them feel depressed and oppressed (Ephesians 6:11-12; 1 Peter 5:8-9). Faw (2004:152) explains that it is clear that sin, or at least evil spiritual powers, can produce serious emotional and behaviour problems similar to those associated with mental illness. However, these cases are best thought of as the exception rather than the rule. Faw (2004:152) further indicates that even during Christ's ministry on earth, when Satan was particularly active, Jesus treated only a few human ailments as cases of demonic control.

f. *Loneliness*

According to Tan and Ortberg (2004:35), loneliness is sometimes defined as the *fear* of love or the *fear* of rejection. Such *fear* or

loneliness can result in depression if it leads to withdrawal from much-needed fellowship and interaction with friends and other people. Murray and Fortinbury (2004:3) concur with this, and show that the real or perceived *fear* of *abandonment* results in depression. They also claim that today's society produces isolation, maltreatment, and disempowerment.

g. *Triggering situations* (cf. *inter alia* DFAQ, 2006; Brown, 2004:83; Brits, 2004b:32; Plutchik, 2003:301; Solomon, 1998)

- Insult, rejection, or failure
- Loss – especially of a loved one or object
- Life stress and change, especially if too much or too quickly – in a short period of time
- Lack of positive, reinforcing or rewarding events in lifestyle
- Reaction to success
- Learned helplessness in uncontrollable situations, or learning over a number of experiences that one's responses make no difference to outcomes, leading possibly to passivity and depression.

h. *Irrational, unbiblical self-talk or misbeliefs*

Cognitive therapists like Dr. Aaron Beck and Dr. Albert Ellis have emphasised that it is not triggering situations *per se* that result in depression, but a person's *mental attitude* or *self-talk* (implicit beliefs, expectations, interpretations of events/situations, meanings, etc.) in response to such situations that is responsible for emotional states such as depression (cf. Solomon, 1998).

i. *Anger turned inward against the self*

Some mental health practitioners, especially those with a more psychodynamic perspective (following Freud and others), suggest that unresolved anger turned inward against one's self can result in

depression (Tan and Ortberg, 2004:36; cf. Brits, 2004b:33; Solomon, 1998).

j. Biological constitutional factors

Biologically oriented therapists and psychiatrists often attribute severe depression and bipolar (manic depressive) disorders to an imbalance in brain biochemistry that may be related to genetic factors and/or constitutional predispositions, as well as environmental and life stress (cf. Faw, 2004:149; Brits, 2004b:32; Koenig, 1999:132; 2.3.5).

k. Existential vacuum

Depression may at times be due to meaninglessness and emptiness, or an existential vacuum, in life. Mild depression is experienced by almost every person at times and may be simply due to the "pain of being human" in a fallen world (Tan and Ortberg, 2004:37).

l. Spiritual "dark night of the soul"

There are times when depression is associated with spiritual dryness and an experience that has been called the "dark night of the soul" by St John of the Cross (cf. Isaiah 50:10).

m. Interpersonal factors

Serious interpersonal or relationship problems may also lead to depression. For example, about 50 percent of depressed people also experience chronic marital discord.

n. Larger societal/cultural factors

Factors like political unrest, economic recession, modernisation and industrialisation, high divorce rates, and poverty may also contribute to higher rates of depression. The actual *expression* of depression in terms of specific symptoms is also affected by ethnic and cultural factors (Tan and Ortberg, 2004:39; cf. Brown, 2004:88).

According to Valfre (2001:238-239), much has been learned over the past decade about the *physical* nature of mood disorders, including the complexity of the causes of these disorders. She suggests that when sad moods deepen and persist, the individual is unable to restore emotional equilibrium or balance because of unusual stress or poor internal regulation. She lists the possible causes of the faulty regulatory mechanism or excessive stress as:

a. *Genetic susceptibility*

   High rates of depression and bipolar illness are seen in individuals who have relatives with mood disorders (Valfre, 2001:238; cf. Gilbert, 2001:15; Brown, 2004:88; DFAQ, 2006).

b. *Biochemical imbalances (neurotransmitters, hormones)*

   Studies of the effects of neurochemical messengers (neurotransmitters) and hormones on behaviour have revealed that behaviours and body chemistries are interrelated. According to Valfre (2001:238; cf. Zohar & Marshall, 2001:45; Plutchik, 2003:304) the major neurotransmitters, the monoamines norepinephrine and serotonin, excite or inhibit the brain circuits involved in mood regulation. Monoamines are longer acting and actually modify the sensitivity of the neurons. When an imbalance in this complex system occurs, depression occurs (cf. Burkett, 1998:123). Zohar and Marshall (2001:46) also argue that in depression there is often too little dopamine and noradrenaline present in some areas. Too much noradrenaline however, can give rise to mania.

   One of the ways the pituitary gland controls the secretions of hormones in the body is by balancing thyroid and adrenal hormones. This balance if often poorly regulated in those with mood disorders. Valfre (2001:238) claims that serotonin, estrogen and progesterone imbalances may help explain the fact that women are more than twice as likely to develop depression (cf. DFAQ, 2006; 2.3.5).

c. *Childhood and adult experiences*

Family relationships are important. Valfre (2001:239) indicates that adults who were not nurtured as children are at higher risk for depression. Losses, role changes, and physical illnesses have an impact on the development of emotional problems. A history of significant trauma during childhood may be a factor in aggravating and at times causing the symptoms of depression (Whitfield, 2003:149). According to Felitti (2002) adverse childhood experiences are both common and destructive. After an extensive study he has found that they have a powerful correlation to adult health half a century later. According to Sandford and Sandford (as quoted by Coetzer, 2005a:47), prenatal as well as birth trauma can also result in depression in later life.

d. *Social circumstances*

According to Valfre (2001:239), poor social support, such as few friends and no significant others, heightens the loneliness of individuals, and repeated reactions to stress and crises wear down one's emotional resistance.

According to Lyles (2004), bipolar disorder is very much a genetically based disorder with a cyclical and spontaneous onset that often involves severe mood swings. Whitfield (2003:55) disagrees, arguing that evidence for a possible genetic cause of bipolar disorder is scant, and no more than 10% of people with the disorder will have a parent who also has it. People with bipolar disorder may have a frequent history of childhood trauma (Whitfield, 2003:53).

Fowler (1999) gives the following summary of the possible causes of depression, which include spiritual roots:

A. *Presenting causes*:

1. *Non-personal*
   a. Death of loved one
   b. Reversal of pleasurable circumstances
   c. Sickness, exhaustion, hormonal changes, inadequate nutrition
   d. Everything is so bad; life is so hard; world is a mess; hopelessness
   e. Tasks seem overwhelming – student, wife, employee
   f. Feel trapped in marriage, parenting, job, financially bound
2. *Inter-personal*
   a. Mistreated, oppressed, mocked, rejected
   b. Taken advantage of
   c. Inadequacy to meet expectations of husband, boss, children
3. *Intra-personal*
   a. Unfulfilled aspirations – to be married, have children, have a home, get a raise, be successful
   b. Unfulfilled desires of worth, identity, belonging, usefulness, etc.
   c. Feeling inadequate to respond to repetitive indulgent desires to eat, drink, sex, etc.
   d. Self-pity, envy, jealousy

B. *Behavioural cause*:

1. *Selfishness* – Personal interest (Isaiah 53:6)
2. *Guilt*
   a. of failing to respond to God's opportunities by relying on God's sufficiency.
   b. of wrong action – personal aspiration, gratification, reputation.
      (1) immorality
      (2) negligence
   c. of wrong reaction – fight, fright, flight.
      (1) anger
      (2) resentment, bitterness

C. *Root cause*

1. Delusion of the Deceiver, Satan, "the father of lies" (John 8:44)
2. Promotes hopelessness – God in Christ not sufficient.

Brits (2004b:33) proposes that substances and drugs may cause depression. Alcohol and illicit substances such as crack, cocaine and ecstasy cause serious depressive symptoms. Certain drugs used in the treatment of medical conditions may also cause a depressed mood. According to Zuckerman (2000:350; cf. Plutchik, 2003:304; Brits, 2004b:33), these include:

- Antiarrhythmics
- Anticonvulsants
- Antihistamines
- Antihypertensives
- Antimicrobials
- Anti-Parkinsonian agents
- Chemotherapeutic agents
- Hormone preparations
- Nonsteroidal anti-inflammatory drugs
- Sedatives
- Withdrawal state (especially from cocaine and other stimulants, amphetamines)
- Other: Cimetidine, ranitidine, disulfiram, etc.

Very often, **a combination of genetic, psychological, and environmental factors is involved in the onset of a depressive disorder**. Later episodes of illness typically are precipitated by only mild stresses, or none at all (DFAQ, 2006; Tan & Lyles, 2005:149). However, there are numerous possible causes of depression, with various authors emphasising different causes depending on their theoretical viewpoints and their models of depression. For the purposes of this study none of these possible causes will be excluded, but they will be categorised as follows:

- **Biological factors**: an imbalance in brain biochemistry that may be related to genetic factors and/or constitutional predispositions, as well as environmental and life stress.
- **Physical factors**: lack of sleep, lack of regular exercise, poor diet or nutrition, overwork or exhaustion, some types of physical illness/condition (hypothyroidism, stroke, a heart attack, cancer, Parkinson's disease, and hormonal disorders), postnatal response, substance abuse.
- **Faulty social interactions**: serious interpersonal or relationship problems.
- **Larger societal/cultural factors**: political unrest, economic recession, modernisation, industrialisation and poverty.
- **A history of situational causes and a group of learned responses**: childhood trauma; learned helplessness in uncontrollable situations, or learning over a number of experiences that one's responses make no difference to outcomes, leading possibly to passivity.
- **Spiritual factors**: negative, sinful attitudes or feelings like bitterness, resentment, unresolved anger turned inward against one's self or hatred; guilt and unrepentance over present sinful behaviour or attitudes; backsliding or turning away from the Lord and his Word; fear of the future and lack of trust in God as sufficient provider; unbelief in general; God-sent trials; meaninglessness and emptiness, or an existential vacuum, in life; spiritual dryness (see 3.3.4).
- **Irrational, unbiblical self-talk or misbeliefs**: it is not the triggering situations per se that result in depression, but a person's *mental attitude* or *self-talk* (implicit beliefs, expectations, interpretations of events/situations, meanings, etc.) in response to such situations.

2.3.4 Symptoms of depression

No single symptom can by itself define the presence of *depression* (Tan & Ortberg, 2004:14; cf. Gilbert, 2001:10) and it is not always easy to distinguish ordinary, run-of-the-mill unhappiness from clinical depression. People

sometimes report deeper feelings of sadness when depression is *less* serious. The DSM-IV-TR (APA, 2000:356) lists the following criteria for a major depressive episode:

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (feeling sad or empty) or observation by others (appearing tearful. In children and adolescents, this may be displayed thought an irritable mood).
- Markedly diminished interest or pleasure in all or almost all activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
- Significant weight loss when not dieting or weight gain (a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. In children, the manifestation may be a failure to make expected weight gains.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

According to Tan and Ortberg (2004:15) *depression* typically involves some or all of the following (cf. Plutchik, 2003:288, 301; Sadock & Sadock, 2003:542; Solomon, 1998):

a. Depressed mood
b. Decreased interest in life
c. Decrease/change in appetite and marked weight loss when not dieting, or weight gain
d. Suicidal tendencies or recurrent thoughts of death
e. Decreased ability to concentrate and indecisiveness
f. Decreased energy or fatigue
g. Insomnia or hypersomnia
h. Decreased sense of self-worth or well-being and inappropriate or excessive feelings of guilt
i. Psychomotor retardation – slowed movements or agitation.

Dr Archibald Hart lists the following symptoms:

a. Mood – there is an unhappy, sad, "blue", or down mood.
b. Thought – there is negative and pessimistic thinking, often accompanied by guilt and self-blame, lack of motivation, problems with concentration and even memory, and suicidal thoughts in the more severe depressions.
c. Behaviour – energy is usually low, with retardation, sluggishness, neglect of personal appearance at times, or even agitation.
d. Physical – several physical symptoms may be present, such as loss of appetite and/or sexual drive, poor or excessive sleep, or loss of weight
e. Anxiety – although feeling down or sad is the major emotional characteristic of depression, anxiety, fears, tension, uncertainty, and indecisiveness may also be present (cf. Tan & Ortberg, 2004:27).

Only in the past two decades has **depression in children** been taken very seriously (DFAQ, 2006). According to Zuckerman (2002:138; cf. Plutchik, 2003:205), children under 7 are usually unable to characterise internal mood states. He has found that most symptoms are similar in children (5-15 years) and adults, but some listed here are slightly different or in addition to adult ones:

a. Cognitions: catastrophising, assumption of personal responsibility for negative outcomes.
b. Lack of interest in playing/favourite activities, isolation, agitation, despair, hypersensitivity, insecurity, boredom, temper tantrums, fugues, feelings of inferiority, nihilistic thoughts, suicidal impulses, obsessive thoughts, loneliness.
c. Irritability, difficulty getting out of bed in morning.
d. School problems: learning difficulties, school refusal/"phobia", dyslexia, concentration difficulties.
e. Vegetative symptoms: fatigue, asthenia, sleep disorders/terrors, appetite changes (very common at different ages), weeping, abdominal pains, alopecia aureata, tics, eczema, allergies, anorexia, bulimia, asthma.
f. Other: fears of parents' dying, clinging, isolation in room, aggression, substance abuse.

Primary signs and symptoms of **depression in adolescents**, according to Valfre (2001:170), are:

a. Moodiness characterised by irritable moods and acting-out behaviour.
b. Decreased social activity.
c. Decreased school performance.
d. Difficulty in thinking.
e. Inability to concentrate, make decisions, or solve problems.
f. Somatic complaints: loss of energy, headache, stomach-ache, eating and sleeping problems.

According to Valfre (2001:170), other interpersonal difficulties are often present in adolescents, such as problems with parents and siblings, the use of drugs, and fighting. Acting out one's depression through antisocial behaviours, such as theft, vandalism, and truancy, may result in clashing with the law and its criminal justice system. Sexual acting out is also common. Valfre (2001:170) suggests that depression in adolescence is characterised by

irritable moods and acting-out behaviours, in contrast to the classic "depressed mood" and "loss of interest" characteristic of adults. Thus, depressed adults lose interest; depressed teens act out.

According to Guinto (2005:78; cf. DFAQ, 2006), depression can take on a different form in men than it does in woman. It may look more like a chronic anger or withdrawal, with possibly more physical symptoms such as headaches and backaches.

Valfre (2001:242) points out that behaviours associated with depression (see table below) should be studied carefully, because a client's nonverbal messages may be the only clues to the presence of this mood disorder. Valfre (2001:242) tabularises the behaviours associated with depression as follows:

Behaviours associated with depression (Valfre, 2001:242)

Emotional	Physical	Intellectual	Behavioural
Anger	Abdominal pain	Ambivalence	Aggressiveness
Anxiety	Anorexia or	Confusion	Agitation
Apathy	overeating	Inability to	Alcoholism
Bitterness	Backache	concentrate	Altered activity
Dejection	Chest pain	Indecisiveness	level
Denial of feelings	Constipation	Loss of interest	Drug addiction
Despondency	Dizziness	and motivation	Intolerance
Guilt	Fatigue	Pessimism	Irritability
Helplessness	Headache	Self-blame	Lack of
Hopelessness	Impotence	Self-depreciation	spontaneity
Loneliness	Indigestion or	Self-destructive	Overdependence
Low self-esteem	nausea	thoughts	Poor personal
Sadness	Insomnia	Uncertainty	hygiene
Sense of	Lassitude		Psychomotor
personal	Menstrual changes		retardation
worthlessness	Sexual non-		Social isolation
	responsiveness		Tearfulness
	Sleep disturbances		Underachievement
	Vomiting		Withdrawal
	Weight change		

Table 2.4

The symptoms listed above apply to depression in its various forms, but in the case of *bipolar* or manic-depressive disorder, periods of depression alternate with periods of mania or mood elevation and excessive energy and behaviours. If this period is slightly less severe than full-blown mania, it is called *hypomania* (Tan & Ortberg, 2004:28). According to Papolos and Papolos, periods of *hypomania* or the more *severe state of mania* are characterised by the following symptoms:

a. Persistently "high" (euphoric) or irritable (dysphoric) or agitated moods
b. Significant shifts in mood
c. Less need for sleep
d. Disturbances in appetite or eating
e. Increased activity, sociability, or sexual drive
f. Rapid, pressured speech
g. Quickly changing thought patterns that are difficult for others to follow, with racing thoughts
h. Loss of judgement and self-control
i. Impulsive and reckless behaviour, especially excessive spending
j. Inflated, grandiose ideas about oneself and one's capabilities
k. Delusional or psychotic thinking, especially of the paranoid type – in the manic state (cf. Tan & Ortberg, 2004:28).

Gilbert (2001:4) argues that depression has an effect on many aspects of people's lives and gives the following summary:

- *Motivation*

Depression affects one's motivation to do things. One can feel apathetic and experience a loss of energy and interest – nothing seems worth doing, everything is so pointless that it is hopeless even to try. If one has children, one can lose interest in them and then feel guilty. A work project about which one might have been very keen becomes boring. One has to drag oneself around. Each day can be a torment of having to force oneself to perform even the most minor of activities.

- *Emotions*

People often think that depression is only about low mood or feeling fed-up, and this is certainly part of it. Indeed, the central symptom of depression is called *anhedonia* – derived from the ancient Greek meaning "without pleasure" – and means the *loss of the capacity to experience any pleasure.* Life seems empty; one is joyless.

However, although one loses the ability to have positive feelings and emotions, one can experience an increase in negative emotions, especially anger. One may be churning inside with anger and resentment that one cannot express. One might become extremely irritable, snap at one's children and relatives and at times lash out at them. One may then feel guilty about this, and this makes one more depressed. Other very common symptoms are *anxiety* and *fear*. When one is depressed, one can feel extremely vulnerable. Things that one may have done easily before seem frightening, and at times it is difficult to know why. Thus, the two "A's" – *anger* and *anxiety* – are very much part of depression. Other negative feelings that can increase in depression are sadness, guilt, shame, envy and jealousy (cf. Plutchik, 2003:298).

- *Thinking*

Depression interferes in two ways with the way one thinks. Firstly, it affects concentration and memory. One finds that one cannot get one's mind to settle on anything. Reading a book or watching television becomes impossible. One also does not remember things too well, and one is prone to forget things. However, it is easier to remember negative things than positive things. Gilbert (2001:5) explains that the second way that depression affects one's thoughts is on the way one thinks about oneself, one's future and the world. Very few people who are depressed feel good about themselves. Generally, they tend to see themselves as inferior, flawed, bad or worthless. The future seems dark, a blank or a never-ending cycle of defeat and losses. Like many strong emotions, depression pushes one to more extreme forms of thinking. One's thoughts become "all or nothing" – one is either a complete success or an abject failure.

- *Images*

When one is depressed, the imagery one uses to describe it tends to be similar. One may talk about being under a dark cloud, in a deep hole or pit, or a dark room. Winston Churchill called his depression his "black dog". The imagery of depression is always about darkness, being stuck somewhere and not able to get out. Therefore, darkness and entrapment are key internal images.

- *Behaviours*

One's behaviour changes when one becomes depressed. One engages in much less positive activity and may withdraw socially and want to hide away. Many of the things one might have enjoyed doing before becoming depressed now seem like an ordeal. Because everything seems to take so much effort, one does much less than one used to. One's behaviour towards other people can change, too. One tends to do fewer positive things with others and is more likely to be in conflict with them. If one becomes very anxious, one might also start to avoid meeting people or lose one's social confidence.

Depressed people sometimes become agitated and find it extremely difficult to relax. They reel like trapped animals and pace about, wanting to do something but not knowing what. Sometimes, the desire to escape and run away can be very strong. However, where to go and what to do is unclear. Some depressed people, on the other hand, become very slowed down. They walk slowly, with a stoop, their thoughts seem stuck, and everything feels "heavy".

- *Physiology*

When people become anxious about something, their bodies can produce a surge of adrenaline. In addition, depression can result in other biological changes, affecting one's body and one's brain. Gilbert (2001:6) argues that there is nothing sinister about this. To say that one's brain works differently when one is depressed is actually to state the obvious: any mental state, be it

happy, sexual, excited, anxious or depressed, will be associated with physical changes in one's brain. Recent research has shown that some of these are related to stress hormones such as cortisol, which indicates that depression involves the body's stress system. Certain brain chemicals, called neurotransmitters, are also affected. Generally, these chemicals, are reduced in the brain when people are depressed, and this is why some people find benefit from drugs that allow the monoamines to build up (cf. 2.3.3).

Probably as a result of the physical changes that occur in depression, one can experience a host of other unwanted symptoms. Not only are energy levels affected, so is sleep. If one is depressed, one may wake up early, sometimes in the middle of the night or early morning, or one might find it difficult to get to sleep. There are some depressed states, however, in which sleep is increased. In addition, loss of appetite is quite common and food may start to lose its taste; as a result, sometimes there is weight loss. Other depressed people may eat more and put on weight.

- *Social relationships*

Even though one might try to hide one's depression, it almost always affects other people: a depressed person is less fun to be with, can be irritable and is continually saying "no". The key issue here is that this is quite common and has been since humans first felt depressed. Therefore, one needs to acknowledge these feelings and not feel ashamed about them, for if one does, it will only make one more depressed. There are various reasons why one's relationships might suffer: there may be conflicts that one feels unable to sort out; there might be unvoiced resentments; one might feel out of control; or one's friends or partner might not understand what has happened to one. Depression is difficult for others to comprehend at times (Gilbert, 2001:6).

2.3.5 People at risk for depression

Depression is no respecter of status or fortune, as it afflicts politicians and world leaders, recipients of various prestigious awards, actors, musicians –

people from all walks of life (Gilbert, 2001:3; cf. Biebel & Koenig, 2004:15). Many famous people throughout history have suffered from it. King Solomon, Abraham Lincoln, Winston Churchill and the Finnish composer Jean Sibelius are well-known examples from history (cf. 3.3.4). What is important to remember is that depression is not about human weakness (Gilbert, 2001:3).

Some people are more at risk for depression than others (Tan & Ortberg, 2004:17; Gilbert, 2001:9). Not only is depression on the rise; some researchers feel that people are becoming depressed at earlier stages than in previous generations. The TWA (2006:171) reports that in a one-year period, 3 times as many persons with depression were 18 to 29 years old than those who were 60 or older. According to Tan and Ortberg (2004:20; cf. Sadock & Sadock, 2003:536; Brits, 2004b:31), depression can strike at almost any time in life, including early *childhood*, although it is most common in *adults*. Kaelber (2002) points out that depression is the second leading cause of disability for persons between the ages of 15 and 44. According to Plutchik (2003:302), the highest prevalence of depression occurs in the mid-40s. Sitton (s.a.; cf. DFAQ, 2006) has found that aging can bring changes and losses which often result in depression. Johnson (1993:438) is of the opinion that depression is the most common psychiatric disorder in the *elderly* population. According to TWA (2006:171) in a given year, 1-2% of people over age 65 suffer from major depression. DFAQ (2006) indicates that when depression develops in the elderly, it may be dismissed as a normal part of aging. Depression in the elderly, undiagnosed and untreated, causes needless suffering for the family and for the individual who could otherwise live a fruitful life.

According to Valfre (2001:240), the following adults are at a higher risk of depression:

a. Women
b. People between the ages of 35 and 44
c. Caucasians and Hispanics
d. Individuals with fewer than 12 years at school

e. People who live in major urban areas
f. People with physical illness
g. Recently widowed older adults
h. People who live in the Western region of the United Sates

Gilbert (2001:9) provides the following statistics regarding *major depression*:

	Women	***Men***
Suffering depression at any one time	4-10%	2-3.5%
Lifetime risk	10-26%	5-12%

Table 2.5

What this suggests is that about one in four or five of people could have some kind of depressive episode at some point in their lives. It also implies that depression is about three times more common in women than in men (cf. TWA, 2006:171; Tan and Ortberg, 2004:17; Sadock & Sadock, 2003:535; Plutchik, 2003:302).

According to Kaelber (2002; cf. DFAQ, 2006) depression will occur in 10-25 percent of women and 5-12 percent of men over the course of their lifetimes. Community surveys and treatment programmes have estimated that two to six times more women than men are affected by depression. However, a study as far back as 1991 (published in *Psychological Assessment*, reported in the *Pasadena Star News* of Dec. 23, 1991) involving 23 000 clients and 500 medical practitioners already suggested that this may be changing. According to Tan and Ortberg (2004:17), clinicians failed to recognise depression two-thirds of the time it occurred in men (as opposed to one-half the time it occurred in women). They have also found that men are twice as likely as women to resist visiting a doctor if they are feeling depressed, and doctors are less likely to probe for depression with male clients than with female clients (cf. 2.6).

Despite misdiagnosis in men, depression is still more prevalent in women (major depression and dysthymia but *not* bipolar or manic-depressive disorder) (Tan & Ortberg, 2004:17,25; Sadock & Sadock, 2003:535; Brits, 2004b:31). This may be partially due to hormonal factors (cf. 2.3.3) such as postpartum and premenstrual depression (cf. DFAQ, 2006; TWA, 2006:171). Valfre (2001:241) agrees that major depressive disorder occurs twice as often in adolescent girls and adult women than in men and indicates that symptoms may begin at any age, but that the average age of symptom onset is in the early 20s (cf. Marano, 2003). According to Brits (2004b:31), the most first-time episodes occur between the ages of 20-25 years. Meier, Minirth *et al.* (1997:278) believe that depressive episodes may begin at any age, but manic episodes usually begin before age thirty. At least half of the individuals with an initial depressive episode have another depressive episode. They argue that major complications of a manic episode are financial losses and other social consequences of impaired judgement. Tan and Ortberg (2004:17) also state that depression may reflect socioeconomic factors like greater financial pressures on women.

Depression tends to be more common in *separated* or *divorced* persons than those who are married or who have never married. It also tends to strike people of *lower socio-economic status* (Tan & Ortberg, 2004:17; cf. Sadock & Sadock, 2003:536; Gilbert, 2001:10). According to Gilbert (2001:10), new research also indicates that rates of and risks for depression have been steadily increasing throughout the twentieth century, but the reasons for this is unclear. Socio-economic changes, the fragmentation of families and communities, the loss of hope in the younger generation – especially the unemployed – and increasing levels of expectations may all be implicated. Sadock and Sadock (2003:536), however, point out that no correlation has been found between socio-economic status and major depressive disorder. A higher than average incidence of bipolar I disorder is found among the upper socio-economic groups (cf. Plutchick, 2003:302).

According to Condrell *et al.* (s.a) professionals are also at risk for depression for the following reasons. They typically:

- are high achievers who put a lot of pressure on themselves to succeed;
- have more work each day than they can complete and frequently feel overwhelmed by their responsibilities;
- offer services as problem solvers, so they often encounter sad and distressing life situations on a daily basis; and
- are so busy that they never seem to have enough time for their personal lives. Consequently their personal relationships suffer as their lives become unbalanced.

2.3.6 Common myths about depression

The following *ten myths* about depression are listed by Biebel and Koenig (2004:75):

1. One is depressed because one wants to be depressed.
2. One can beat depression with willpower.
3. One is depressed because of unconfessed sins. (The author is of the opinion that unconfessed sins can cause depression).
4. If one is depressed, one is just feeling sorry for oneself.
5. Depressed believers have weak faith.
6. It is easy to tell when one is depressed.
7. *Depression* is just another word for *grief*.
8. Christians will be understanding and supportive.
9. Depression is a waste of time.
10. Depression arises from repressed anger. (The author does not agree that repressed anger can not be a cause of depression).

Carter & Minirth (1995:150-58) also offer a list of myths about depression:

- *"If I live right I can avoid pain."*
  Emotional pain can exist even when it seems it should have been duly alleviated (Carter & Minirth, 1995:150). You can act appropriately, commit to honour and integrity, live conservatively – and yet be afflicted with pain. This is because the world is imperfect. In theological terminology, it is infested with sin. It is certainty that any person can be capable of insensitivity, anger, rudeness, unawareness.

  In spite of such dreary truth, people need not despair. Pain exists, but so does hope. For every problem people encounter there is a coping skill (Carter & Minirth, 1995:150).

- *"Surely (Christian) people will accept and understand me."*
  During times of pain people want understanding, yet many people are not equipped to give it (Carter & Minirth, 1995:154). Afraid of their own emotions, reluctant to get too involved, people will sidestep the possibility of discussing the real issues, leaving the sufferer feeling isolated or misunderstood. Carter & Minirth (1995:156; cf. Biebel & Koenig, 2004:87) suggest that people should not assume that the lack of understanding shown by some is representative of the way all people are. They should, even as they accept the reality of some loneliness, take the initiative to search for those whose main priority is to relate.

- *"Contentment comes from external sources."*
  In the past couple of decades, the psychological world has been flooded with information addressing the importance of a spiritually based sense of security. According to Carter & Minirth (1995:156), some of this information has been misguided because it humanistically encourages people to worship the self or some mystical deity. Some information, though, has been right on target as it emphasises a

personal commitment to the sovereign God who has made provisions for people through the redemptive work of Jesus Christ.

In their dealings with depressed people, Carter and Minirth (1995:156) have discovered that many people publicly portray themselves as God-believing, spiritual beings; yet when they are in a crisis, they revert to the wish that they could be rescued by more satisfactory external circumstances. People should not let others dictate whether or not they will live in the strength that can come from their spiritual life. According to Carter & Minirth (1995:157), though not explicitly stated in Philippians 4:11, there is a very real implication that although circumstances will disappoint, yet God's strength can be found.

- *"I can get rid of my depression forever."*
  According to Carter & Minirth (1995:158) this myth is difficult for depressed people to dispel. The alternative is to admit that they may again struggle with depression. The truth remains that people can still be susceptible to depression because they are not immune to ongoing potentials for rejection, illness, death, and so forth. People should, however, not feel threatened by their susceptibility to depression. Depression does not have to be terminally oppressive. Rather than giving themselves the mandate never to be depressed again, they should make it their goal to be in an ongoing process of monitoring their emotional and relational habits for the purpose of being as balanced as they can be. People can adjust habits and patterns that can greatly reduce the inclination to feel depressed (Carter & Minirth, 1995:158).

The above-mentioned myths can have huge repercussions for those people who believe them. They can:

- make people feel guilty;
- give depression sufferers false hope;

- deny the value of medication;
- make people feel even more removed from God; and
- make people feel that they have a lack of faith;

2.3.7 Assessment scales for depression

There are a number of assessment scales for depression (cf. appendix A). The scales will not be discussed, but give an indication of the state the depression sufferer is in, in order to help with the counselling and healing process. Some of the scales include the following (Zuckerman, 2000:138):

- The Beck Depression Inventory
- The Hamilton Rating Scale for Depression
- The Zung Self-Rating Depression Scale.

2.3.8 Treatments for mood disorders (see 2.4.6)

Mood disorders are very common, and the burden they impose on human health and productivity is enormous (Bear *et al.*, 2001:692). Valfre (2001:244; cf. Brits, 2004b:31) reports that fewer than half of the people with mood disorders receive treatment. Feelings of hopelessness and the stigma of having a mental illness prevent many people from seeking treatment. Others are misdiagnosed or treated for a medical illness because their symptoms are mainly physical. Valfre (2001:244) writes that men are also less likely to receive treatment because they often hide their emotions behind alcohol, drugs or aggression.

Depression responds well to treatment, especially if it is begun early (cf. Tan & Lyles, 2005:153). Serious disturbances of severe depression and bipolar disorders may involve years of therapy (Valfre, 2001:244). Plutchik (2003:304) argues that given the heterogeneity of depressive syndromes, it is not surprising that clinicians have developed a large variety of methods for the treatment of depression. According to Sadock and Sadock (2003:560) the

treatment of patients with mood disorders must be directed toward several goals:

- The patient's safety must be guaranteed.
- A complete diagnostic evaluation of the patient must be carried out.
- A treatment plan that addresses not only the immediate symptoms but also the patient's prospective well-being must be initiated – treatment must reduce the number and severity of stressors in the patients' lives.

Valfre (2001:244) concludes that the therapeutic plan for clients with mood disorders is often arranged into three phases (Figure 2.4):

- The *acute treatment phase* lasts 6 to 12 weeks. The goal during this phase is to reduce symptoms and inappropriate behaviours. In-patient hospitalisation may be required when clients are too impaired to continue with activities of daily living or too suicidal to be left alone.
- The goal of the *continuation phase* is to prevent relapses into distressing emotional states. This period usually lasts from 4 to 9 months and is carried out on an outpatient basis. Medications and psychotherapy are continued. Clients are educated about the nature of their conditions and their medications and encouraged to try new coping behaviours.
- The *maintenance treatment phase* concentrates on preventing recurrences in clients with prior episodes of depression and/or mania. Maintenance psychotherapy and medications help prevent new episodes or recurrences.

The following figure by Prozac depicts the phases of treatment for major depression:

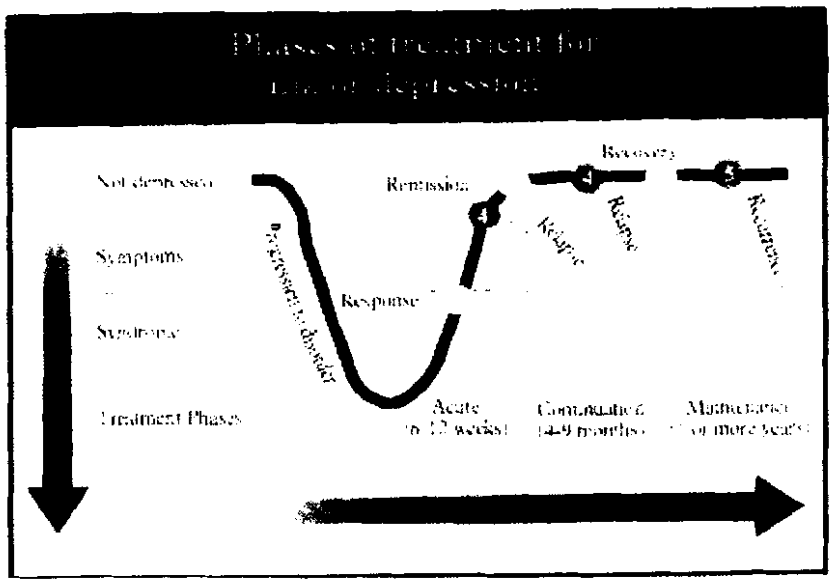


Figure 2.4

According to Tan and Ortberg (2004:39; cf. Sadock & Sadock, 2003:561; Tan & Lyles, 2005:153), *behaviour therapy*, *cognitive therapy* and *interpersonal psychotherapy* have all been found to be effective psychosocial treatments for *major depressive disorder*. Psychosocial and pharmacological or drug interventions for major depressive episodes appear to be equally effective, with some support found for the superior effectiveness of combined psychosocial and pharmacological treatments, although this is less clear for *severely* depressed clients. Brits (2004a:47) postulates that pharmacotherapy and secondary psychotherapy best treat mood and anxiety disorders. Less serious mood or anxiety disorders could be treated by pharmacotherapy and/or psychotherapy but preferably with both methods. Brits (2004a:47) is of the opinion that psychotherapy is only useful in conjunction with pharmacotherapy.

A number of highly effective treatments are available, although they present many treatment challenges (cf. Nevid *et al.*; 2003:248):

Psychotherapies

Various psychotherapies are effective in treating mild and moderate depression (Valfre, 2001:244; cf. Gilbert, 2001:11; Faw, 2004:161). The main goal of psychotherapy, according to Bear *et al.* (2001:692), is to help depressed patients overcome negative views of themselves and the future. The neurobiological basis of the treatment has not been established, although one can infer that it relates to establishing cognitive neocortical control over the activity patterns in disturbed circuits (Bear, *et al.* 2001:692).

Cognitive therapy

Cognitive therapy is a fast-acting technology of mood modification that one can learn to apply on one's own (Burns, 2000:10). A series of recent studies confirms that these techniques reduce the symptoms of depression much more rapidly than conventional psychotherapy or drug therapy (Burns, 2000:10). Cognitive therapy is one of the first forms of psychotherapy which has been shown to be effective through rigorous scientific research under the critical scrutiny of the academic community.

Cognitive therapy can help one eliminate the symptoms and to experience personal growth so one can minimise future upsets and cope with depression more effectively in the future. According to Burns (2000:10), the simple, effective mood-control techniques of cognitive therapy provide:

1. *Rapid symptomatic improvement*: In milder depressions, relief from one's symptoms can often be observed in as short a time as twelve weeks.
2. *Understanding*: A clear explanation of why one gets moody and what one can do to change one's moods. One will learn what causes one's powerful feelings; how to distinguish "normal" from

"abnormal" emotions; and how to diagnose and assess the severity of one's upsets (Burns, 2000:11).

3. *Self-control*: One will learn how to apply safe and effective coping strategies that will make one feel better whenever one is upset.
4. *Prevention and Personal Growth*: Genuine and long-lasting prophylaxis (prevention) of future mood swings can effectively be based on a reassessment of some basic values and attitudes that lie at the core of one's tendency toward painful depressions.

The first principle of cognitive therapy is that *all* one's moods are created by one's "cognitions", or thoughts (Burns, 2000:12; cf. ADAA, 2006; Anderson and Miller; 1999:61). *Cognition* refers to the way one looks at things – one's perceptions, mental attitudes, and beliefs. It includes the way one interprets things – what one say about something to someone or to oneself.

The second principle, according to Burns (2000:12), is that when one feels depressed, one's thoughts are dominated by a pervasive negativity. One perceives not only oneself but the entire world in dark, gloomy terms. Even worse, one will come to believe that things always have been and always will be negative. As one looks into one's past, one remembers all the bad things that has happened to one. As one tries to imagine the future, one sees only emptiness or unending problems and anguish. This bleak vision creates a sense of hopelessness. This feeling is illogical, but it seems so real that one has convinced oneself that one's inadequacy will go on forever (Burns, 2000:13).

The third principle is of substantial philosophical and therapeutic importance. Research has documented that the negative thoughts that causes one's emotional turmoil nearly *always* contain gross distortions. Although these thoughts appear valid, one will learn that they are

irrational or just plain wrong, and that twisted thinking is a major *cause* of one's suffering.

Cognitive-behavioural therapy is used to help clients identify and correct the self-defeating thoughts and actions that keep self-esteem low (cf. Tan & Ortberg, 2004:41; Faw, 2004:162; Plutchik, 2003:306). According to Anderson and Miller (1999:61; Burns, 2000:10), cognitive therapy that focuses on the thought processes of a depressed person, in particular the hopeless and helpless thinking, and by changing the negative thought patterns, has proved to be as effective as the antidepressant imipramine in treating the depression.

Interpersonal therapy assists clients with relationships and interactions, and *psychodynamic therapy* encourages the growth of personal insight (cf. Plutchik, 2003:306). Valfre (2001:244) further claims that *support groups* and *organisations* have also been found very helpful for clients and families coping with mood disorders.

Joubert (2005:224) reports that in most instances *psychiatry* and *psychotherapy* work hand-in-glove; the one cannot do without the other. To only treat a patient psychiatrically with psychiatric medication might stabilise the patient but will not alleviate the psychological sources that lead to the psychopathology in the first place. In the same manner it will not help to just let a patient undergo psychotherapy if the psychopathology has already lead to chemical imbalances. Such a patient will need to be treated with psychiatric medication as well. The following figure explains the relationship between psychiatry and psychotherapy (Joubert, 2005:225):

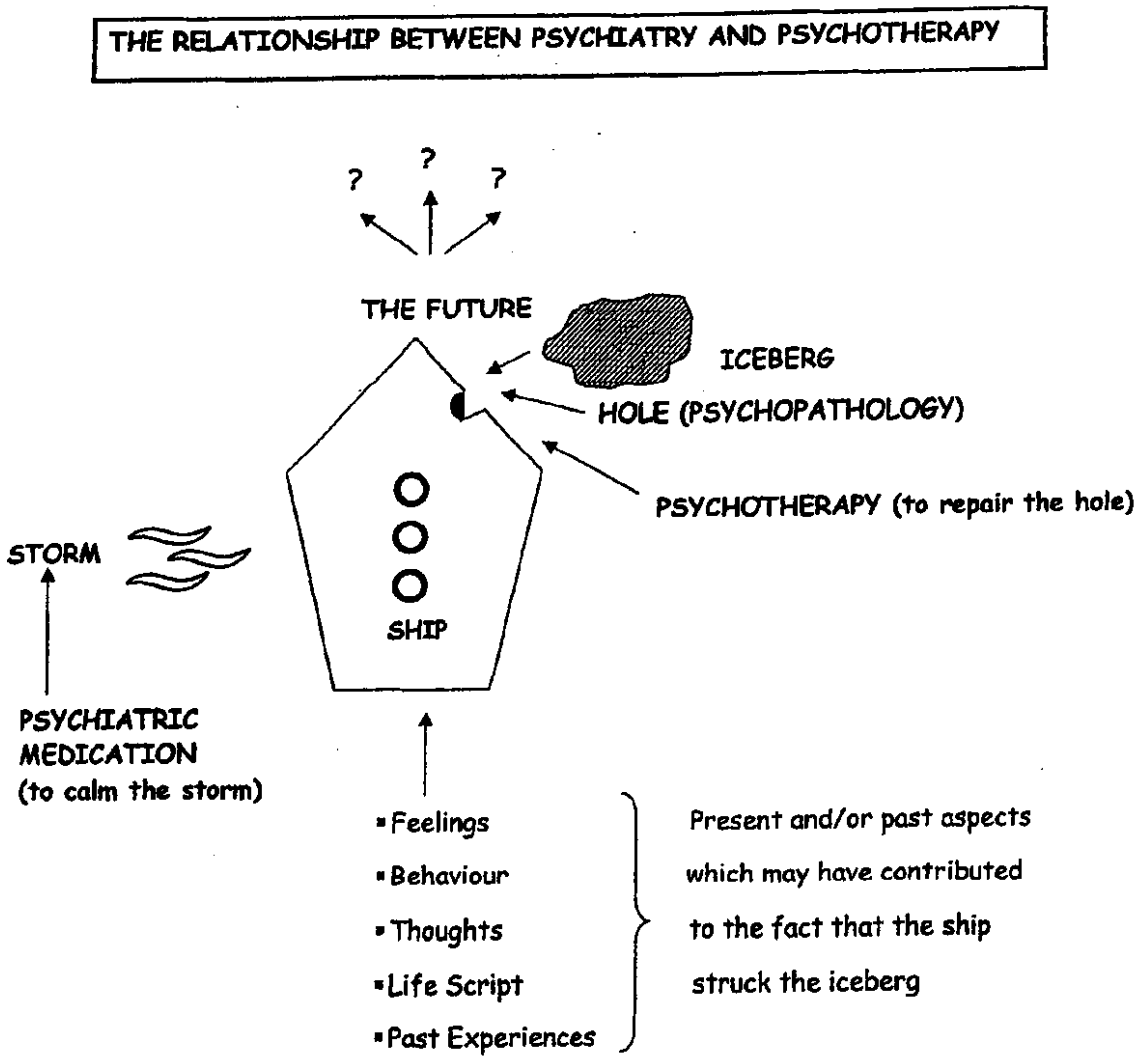


Figure 2.5

Joubert (2005:224) proposes that a patient might be compared to a big passenger ship or oil tanker that has struck an iceberg. The ship has a big hole in its side because of the collision which needs to be fixed. However, the hole cannot be fixed because the ship finds itself in a severe storm in the open sea. Joubert (2005:224) also explains that with reference to the above metaphor, a patient can be regarded as the ship. The hole in the ship is the psychopathology that needs to be treated. However, the patient will not be able to respond positively to the treatment unless the chemical imbalances of the neurotransmitters is stabilised (that is, unless the storm is calmed down). With the

& Sadock, 2003:566) indicate that ECT is sometimes used for suicidal crises because antidepressants do not take effect for a period of two to three weeks and the rapid improvement seen with ECT is needed. Bear *et al.* (2001:692) also mention the fact that relief can occur quickly – sometimes as soon as the first treatment – as an advantage of ECT. They stress that this attribute of ECT is especially important when suicide risk is high.

An adverse effect of ECT, however, is memory loss. Temporal lobe structures, including the hippocampus, play a vital role in memory. Bear *et al.* (2001:692) explain that ECT usually disrupts memories of events that occurred before treatment, extending back 6 months on average. In addition, ECT can temporarily impair the storage of new information. The mechanism by which ECT relieves depression is unknown. As mentioned above, however, one temporal lobe structure affected by ECT is the hippocampus, which is involved in regulating CRH and the HPA axis (Bear *et al.*, 2001:692) (see also 2.3.3).

Drug therapies

The modern era of research on the chemistry of depression accidentally got a big boost in the early 1950s when researchers were testing a new drug for tuberculosis, called *iproniazid* (Burns, 2000:443; cf. 2.3.3). The investigators noticed pronounced mood elevations in a number of patients who received the drug. The iproniazid discovery helped to usher in a new era of biological research on depression (Burns, 2000:444). Researchers knew that iproniazid was an inhibitor of the MAO enzyme. The drug was therefore categorised as an MAO inhibitor, or MAOI for short. Several new MAOI drugs that were similar in chemical structure to iproniazid were developed. It was known that the MAOIs prevented the breakdown of serotonin, norepinephrine, and dopamine, the three chemical messengers that are concentrated in the limbic regions of the brain. Scientists hypothesised that a deficiency in one or more of these substances might

cause depression and that antidepressant drugs might work by increasing the levels of these substances.

Figure 2.6 depicts the neuron structure and limbic system (Joubert, 2005:223) of the brain.

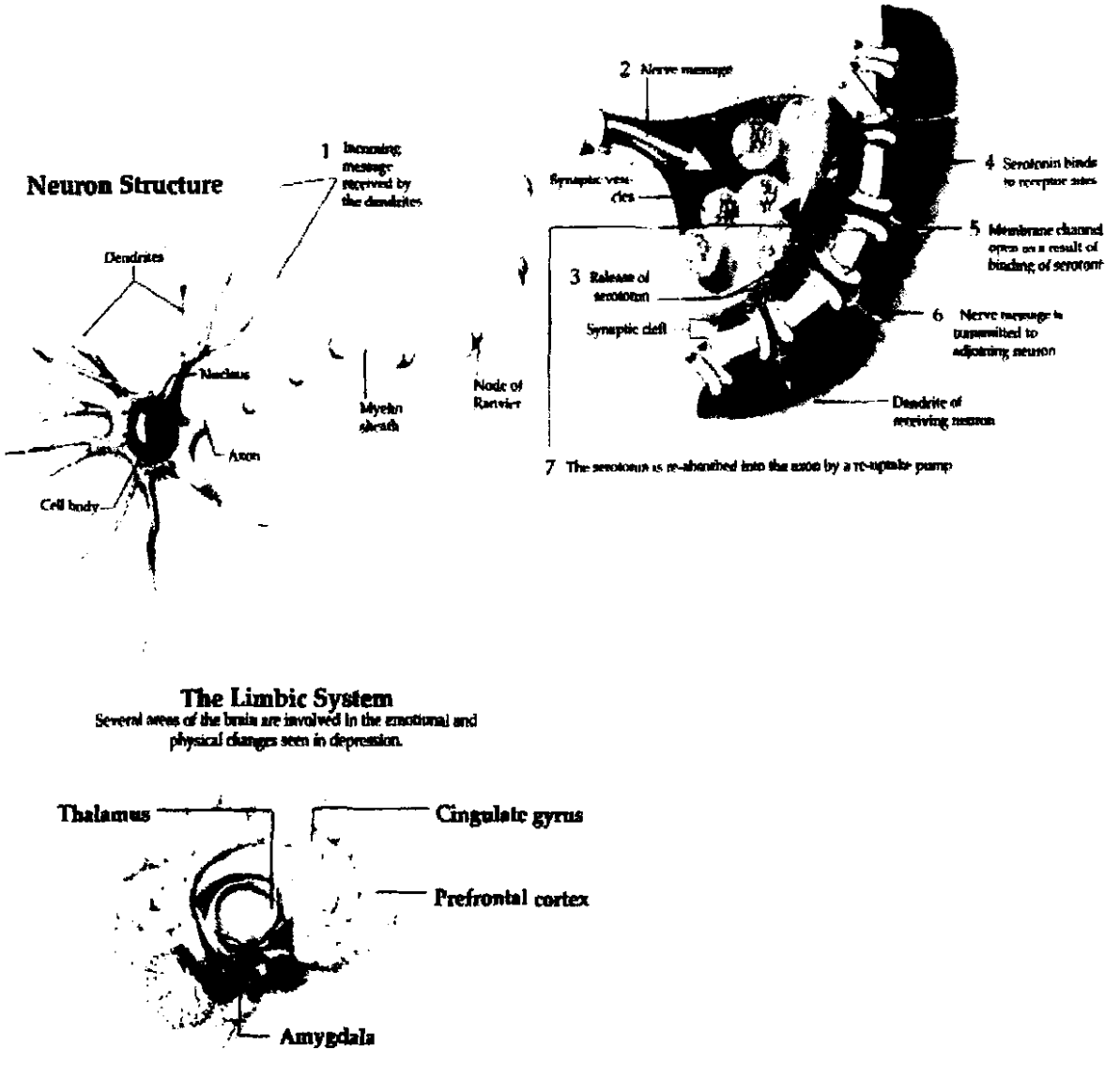


Figure 2.6

When the presynaptic nerve fires, serotonin is released into the synapse (Burns, 2000:445). After it attaches to a receptor on the postsynaptic nerve, it swims back to the presynaptic nerve, where it is pumped back inside this nerve and destroyed by the MAO enzyme. By

preventing the MAO enzyme from destroying the serotonin, the serotonin would accumulate in the presynaptic nerve, because this nerve is always manufacturing serotonin. If this nerve could not get rid of its serotonin, the concentration of serotonin would continue to increase. Whenever the presynaptic nerve fired, it would release much more serotonin than usual into the fluid-filled synaptic region. The excess serotonin in the synapse would cause a greater-than-expected stimulation of the postsynaptic nerve. This is probably why the MAOI drugs cause a mood elevation.

Medications are a mainstay in the treatment of mood disorders (Valfre, 2001:245; cf. Gilbert, 2001:11). Brits (2004b:39) suggests that it is often of no value to try and do psychotherapy or counselling with a person with acute serious symptoms of a major depressive episode, as the *chemical imbalance* in the brain causes him/her not to have sufficient energy or the ability to concentrate to benefit from "talking" therapy. It is then rather indicated to treat the situation pharmacologically before initiating psychotherapy or counselling.

The use of medications must be carefully assessed, monitored, and evaluated because of the possibility of side-effects and drug misuse. The most commonly used drug classes for treating mood disorders are four classes of antidepressants and several mood-stabilising drugs. All work to increase neurotransmitter levels in the body, which leads to improvement of depression (cf. Plutchik, 2003:307; Faw, 2004:162; Anderson & Miller, 1999:63).

Based on their chemical composition, antidepressants are divided into 5 categories: tricyclics, monoamine oxidase inhibitors (MAOIs), selective serotonin re-uptake inhibitors (SSRIs), and atypical antidepressants (cf. Nevid *et al.* 2003:252; Burns, 2000:514). Each type alters a part of the brain's neurochemical balance or function (Valfre, 2001:245). Many antidepressants require from 2 to 4 weeks

before their effects are noticed and the client's well-being improve (cf. Sadock & Sadock, 2003:565). Brits (2004b:41) reports that it can take up to 40 days for the antidepressant to be effective. For this reason some clients believe that the antidepressants are ineffective. Therefore, Valfre (2001:245) argues that the clients require education and reminders that these drugs require time to take effect and encouragement to continue taking their medications. None of the antidepressants are addictive, they are safe when used correctly and the newer drugs are non-toxic (Brits, 2004b:41).

The adaptive response in the brain that is responsible for the clinical effectiveness of these drugs has not been established with certainty (Bear, *et al.*, 2001:693). Nonetheless, an intriguing finding is that clinically effective treatment with antidepressants dampens the hyperactivity of the HPA system in humans. Animal studies suggest that this effect is due to increased glucocortocoid receptor expression in the hippocampus, which occurs in response to a long-term elevation in serotonin. CRH plays a crucial role in the stress response of the HPA axis (Bear, *et al.*, 2001:693). One can imagine that new drugs that act as CRH receptor antagonists are continually being developed for use as antidepressants.

Lithium is highly effective in stabilising the mood of patients with bipolar disorder, not only in preventing the recurrence of mania but also by preventing episodes of depression (Bear *et al.*, 2001:694; cf. Brits, 2004b:42). Lithium affects neurons in many ways. In solution, it is a monovalent cation that passes freely through neuronal sodium channels, Inside the neuron, lithium prevents the normal turnover of phosohatidylinostol (PIP2), a precursor for important second messenger molecules that are generated in response to activation of some G-protein-coupled neurotransmitter receptors. Lithium also interferes with the actions of adenylyl cyclase, important for generation of the second messenger cyclic adenosine monophoshpate (cAMP),

and glycogen synthase kinase, important for cellular energy metabolism. Why lithium is such an effective treatment for bipolar disorder, however, remains completely unknown. As with other antidepressants, the therapeutic effects of lithium require long-term use. The answer again appears to lie in an adaptive change in the central nervous system (CNS), but the nature of this change remains to be determined.

According to Whitfield (2003:14), the diagnosis of depression does not automatically indicate that people will require daily ingesting of antidepressant drugs (ADP's) to heal their condition. Several observers have emphasised that "depression" is not a single disorder, but that it has a number of subtypes (Whitfield, 2003:13; cf. 2.3.2). It is up to the patients and clinicians to keep their awareness at a maximum so they can find the real cause of the depressive symptoms and signs. Whitfield (2003:22) points out that trauma has been overlooked as a major causal factor that underlies many common medical disorders and conditions.

Psychosocial treatments for *bipolar disorder* are *adjunctive* or secondary to the primary treatment involving pharmacological interventions or medications, especially mood stabilisers (Tan & Ortberg, 2004:41). The authors claim that psychosocial treatments have the potential to increase compliance with taking medication, improve quality of life, and enhance strategies for coping with stress. Combining pharmacotherapy and psychosocial treatments for *bipolar disorder* may therefore significantly lower the risk of relapse and re-hospitalisation, and improve the quality of life for clients. Tan and Ortberg (2004:41) propose that *psycho-education*, *cognitive-behaviour therapy* and *marital/family therapy* may all be effective in helping the *bipolar* client.

An overview of the different treatment approaches to depression, according to Plutchik (2003:305; cf. Nevid *et al.*, 2003:248), will be provided below.

Overview of treatment approaches to depression

(Plutchik, 2003:305)

Modality	Definition
Behavioural Therapy	A form of psychotherapy that focuses on modifying faulty behaviour rather than basic changes in the personality. Instead of probing the unconscious or exploring the patient's thoughts and feelings, behaviour therapists seek to eliminate symptoms and to modify ineffective or maladaptive patterns by applying basic learning techniques and other methods. Brief treatment.
Relaxation Training	Teaches techniques to help clients learn to relax, including biofeedback and guided imagery. Brief treatment.
Self-control Therapy	Encourages depressed clients to attend positive events, to set realistic self-expectations, to increase self-reinforcement and decrease self-punishment. Brief treatment.
Social Skills Training	Teaches clients communication and social interaction skills. Brief treatment.
Cognitive Therapy	A psychotherapeutic approach based on the concept that emotional problems are the result of faulty ways of thinking and distorted attitudes toward oneself and others. The therapist takes the role of an active guide who helps the patient correct and revise perceptions and attitudes by citing evidence to the contrary or eliciting it from the patient himself/herself. The therapist uses cognitive and behavioural techniques to correct distortions of thinking associated with depression, i.e. permission about oneself, the world, and the future. Brief treatment.
Interpersonal Psychotherapy	A form of psychotherapy in which the therapist seeks to help the patient to identify and better understand interpersonal problems and conflicts and to develop more effective ways of relating to others. The therapist focuses on the client's

Modality	Definition
	current interpersonal relationships. Helps clients learn more effective ways in relating to others and coping with conflicts in relationships. Brief focused treatment.
Psychodynamic Psychotherapy	Any form or technique of psychotherapy that focuses on the underlying, often unconscious drive and experiences that determine behaviour and adjustment. Usually long treatment.
Feminist Therapy	A form of psychotherapy that views symptoms as reactions to cultural oppression rather than simply as intrapsychic phenomenon. It focuses on empowerment of the clients. Clients are helped to understand that depression stems, in part, from the cultural role of women in society. Typically open ended.
Marital and Family Therapy	Treatment of marital partners or parents and children. Wide range of treatment strategies, including insight-oriented and systems-oriented therapy, communication skills training, and reinforcement strategies. May be time limited or open ended.
Group Therapy	Psychotherapy in a group setting. Typically led by a trained therapist. May be interpersonally, behaviourally, or insight oriented. Provides cohesiveness and support, sharing of feelings and experiences, feedback about interpersonal skills, and problem solving.
Support	Peer self-help and consciousness-raising groups. People provide support for each other in a setting that encourages sharing feelings and innovative problem solving, may be leader-led or leaderless. Typically open-ended.
Pharmacotherapy	The use of pharmacological agents in the treatment of mental disorders in conjunction with psychotherapy.

Modality	Definition
Electroconvulsive Treatment	The patient is prepared by administration of barbiturate anaesthesia and injection of a chemical relaxant. An electric current is then applied for a fraction of a second through electrodes placed on the temples, which immediately produces a two-stage seizure (tonic and clonic). The usual treatment is bilateral, but unilateral stimulation of a nondominant hemisphere has been introduced in order to shorten the period of memory loss that follows the treatment.

Table 2.6

In summary, it is critical to diagnose the actual underlying causes of mental and physical disorders before a specific treatment regimen is prescribed.

2.3.9 Recurrence of depression

According to Brits (2004b:37), 75% of people with depressive disorders recover within one year. Episodes of major depression rarely last longer than 2 years. Without treatment, however, depressions recur in 50% of cases, and after three or more episodes, the odds of recurrence increase to more than 70% (Bear *et al.*, 2001:687). Stressful life events are also associated with increases in relapse rates, among patients with mood disorders (Sadock & Sadock, 2003:560).

Nierenberg *et al.* (2003:13) postulate that major depressive disorder is a *chronic* disorder, frequently characterised by relapses and recurrence (cf. Sadock & Sadock, 2003:560; Gilbert, 2001:9). Brits (2004b:37; cf. Salloum *et al.*, 2000:55) reports that recurrent episodes happen in 50-80% of patients (5-6 per lifetime). One of the major risk factors for additional episodes of depression is the residual symptoms that persist after a depressive episode ends; these residual symptoms tend to progress to another depressive episode. The authors also mention that although relapse or recurrence may

be prevented with long-term pharmacotherapy, this approach is recommended only for patients at high risk of relapse or recurrence. Patients not at high risk who are effectively treated to full remission have a substantially lower risk of developing another depressive episode. In addition, psychotherapy, alone or combined with medication, has been shown to be effective in preventing further episodes of depression (Nierenberg *et al.*, 2003:13).

Although some factors are prognostic of the short-term recurrence of depression, Yager (1999) stresses that after extended research little is known about specific prognostic factors over longer periods. Extending a 10-year follow-up study, his 15-year naturalistic study adds to knowledge about the long-term course of major depressive disorder. Researchers followed two groups of patients after an index episode of depression: a cohort of 380 who had recovered and a sub-sample of 105 who then remained well for at least five years. For the complete cohort, 82% had at least one other episode; 78% of these recurrences were *major depression*, and 22% involved *mania*, *hypomania*, or *schizoaffective* disorders. Of the sub-sample, 58% relapsed after five years; 90% of relapses involved *major depression* and 10% *hypomania*. Factors associated with recurrences in the cohort included being female, having never married, having had a longer period of depression before treatment, and having had more prior episodes. No factor was predictive for the sub-sample. The intensity and amount of antidepressant treatment in all patients tended to diminish from initial doses or recommended levels. During the month before recurrence, 77% of the complete cohort were medication-free. Thus, according to Yager (1999), better long-term antidepressant treatment might reduce risks of recurrence.

According to Tan and Ortberg (2004:41) *marital/family therapy* can be successfully combined with medication to decrease recurrences of *bipolar disorder* and improve occupational and social functioning.

2.4.1 Defining anxiety

Part of the problem in defining anxiety is that it has acquired several different connotations in ordinary usage (Plutchik, 2003:315; cf. Öhman, 2004:574). For example, one might say "I am anxious about my job interview tomorrow", meaning that the individual is *worried* about the outcome of this particular encounter. Someone might also say, "I am anxious to go on safari to Africa", meaning in this case that the individual is *eager* to go. Anxiety disorders are the cause of neuroses, psychoses, and psychophysiologic disorders (cf. Plutchik, 2003:314). It can be the cause of phobias. It can be the real underlying problem in people who think they have committed the unpardonable sin (Minirth & Meier, 2002:170; cf. 3.3.1). Plutchik (2003:315) explains that psychiatrists use the term *anxiety* as a theoretical term referring to an underlying basis of neurosis. Many psychologists, like Barlow, use the term as a description of *a sense of uncontrollability focused largely on possible future threats, danger, or other upcoming potentially negative events, in contrast to fear, where the danger is present and imminent* (cf. Plutchik, 2003:315; Anderson *et al.*, 2000:268). According to Sadock and Sadock (2003:281), anxiety can be defined as a feeling of apprehension caused by anticipation of danger, which may be internal or external. Koenig (2005:277; cf. Middleton, 2004:270; Nevid *et al.*, 2003:159) defines anxiety as an emotion associated with some type of internal or external threat to physical or emotional well-being. It is accompanied by a sense of fear or worry about the future, whether in response to a distinct event, or to no event in particular. It may include feelings of physical restlessness and tremulousness (Koenig, 2005:277; cf. Öhman, 2004:574).

Fear and anxiety are the emotional or felt reactions to one's perception of life events; they do not occur in a vacuum. Anxiety disorders are a life problem, and to solve them, one must consider how the *whole* person (cf. 3.2) is responding to threatening events or potential disasters (Anderson & Miller, 1999:52).

2.4.2 The difference between anxiety and fear

Sadock and Sadock (2003:591; cf. Koenig, 2005:83) have found that *anxiety* is an alerting signal; it warns of impending danger and enables a person to take measures to deal with a threat. Fear is a similar alerting signal but should be differentiated from anxiety (cf. Öhman, 2004:588). According to Sadock and Sadock (2003:591; cf. Plutchik, 2003:315) *fear* is a response to a known, external, definite, or nonconflictual threat, whereas; *anxiety* is a response to a threat that is unknown, internal, vague or conflictual. Fear differs from anxiety and from panic attacks, because legitimate fears have an object (Anderson *et al.*, 2000:268).

Izard and Ackerman (2004:260) explain that the unique function of *fear* is to motivate escape from dangerous situations. Fear anticipation motivates *avoidance behaviour*. Whether the threat is physical or mental or both, fear performs its basic function of motivating escape and *alleviating* fear-eliciting conditions (Izard & Ackerman, 2004:260). According to Plutchik (2003:314) clinicians are particularly interested in fear because they consider it to be the *central ingredient* of anxiety, and depression rarely occurs without associated fear or anxiety (see 2.5).

2.4.3 Types of anxiety disorders

Psychiatrists have pointed out that there seem to be at least two *kinds* of anxiety (Plutchik, 2003:318; cf. Öhman, 2004:574). One is a feeling of *panic* that occurs at unpredictable times. The second is called *anticipatory anxiety*, which is a fear that the panic attack will occur. Plutchik (2003:318) has found that one reason for the distinction is that anticipatory anxiety may be temporarily reduced by sedatives that have little or no effect on panic attacks. At the same time, antidepressant medications seem to be able to block panic attacks but have no effect on anticipatory anxiety. Middleton (2004:271) identifies four levels of anxiety: *mild*, *moderate*, *severe*, and *panic*. According to Hart and Weber (2005:168), symptoms and intensity range from "mild"

response to stressful or challenging situations to "intense" fear and a troublesome disorder, which interferes with daily functioning and a sense of well-being.

The ADAA (2006; cf. Nevid *et al.*, 2003:161) identifies the following five *anxiety disorders*:

- *Panic Disorder*

  The DSM-IV-TR (APA, 2000:429) describes *panic disorder without agoraphobia* as being characterised by recurrent unexpected panic attacks about which there is persistent concern. *Panic disorder with agoraphobia* is characterised by both recurrent unexpected panic attacks and agoraphobia (APA, 2000:429). A *panic attack*, according to DSM-IV-TR (APA, 2000:429), is a discrete period in which there is the sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During these attacks, symptoms such as shortness of breath, palpitations, chest pain or discomfort, choking or smothering sensations, and fear of "going crazy" or losing control are present (APA, 2000:429). *Agoraphobia* is anxiety about or avoidance of places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having a panic attack or panic-like symptoms (APA, 2000:429).

  According to Plutchik (2003:317), the most dramatic expressions of anxiety disorders are panic attacks. Plutchik (2003:317) points out that these experiences usually occur spontaneously without an obvious cause, although sometimes the sense of being trapped in an elevator, an airplane, or a tunnel triggers them. People with panic disorder suffer severe attacks of panic – which may make them feel like they are having a heart attack or are going crazy – for no apparent reason (ADAA, 2006; cf. Faw, 2004147). According to Sadock and Sadock (2003:599), panic attacks can vary from several attacks during one day to only a few attacks during a year. The central feature of a panic

attack is an overwhelming feeling of *terror* (Plutchik, 2003:317). Symptoms include heart palpitations, chest pain or discomfort, dizziness, sweating, trembling, tingling sensations, feeling of choking, fear of dying, fear of losing control or going crazy, and feelings of unreality (ADAA, 2006; cf. Plutchik, 2003:317; Strong, 2003:18). Panic disorder often occurs with agoraphobia, in which people are afraid of having a panic attack in a place from which escape would be difficult; as a result, they avoid these places (cf. Strong, 2003:13). According to Middleton (2004:283), a panic disorder may commence at any time during life, but occurs most often in the mid-teens and early adulthood.

- *Obsessive-Compulsive Disorder* (OCD) – (cf. Crawford, 2005:181)
  According to the DSM-IV-TR (APA, 2000:429), *obsessive-compulsive disorder* is characterised by obsessions (which cause marked anxiety or distress) and/or by compulsions (which serve to neutralise anxiety).

  In OCD, individuals are plagued by persistent, recurring thoughts (obsessions) that reflect exaggerated anxiety or fears (cf. Strong, 2003:14); typical obsessions include worry about being contaminated or fears of behaving improperly or acting violently. The obsessions may lead an individual to perform a ritual or routine (compulsions) – such as washing hands, repeating phrases or hoarding – to relieve the anxiety caused by the obsession (cf. Faw, 2004:147; Middleton, 2004:285; Sadock & Sadock, 2003:616). However, the completion of the compulsive act may not affect the anxiety, and it may even increase the anxiety (Sadock & Sadock, 2003:616). Anxiety is also increased when a person resists carrying out a compulsion. According to Middleton (2004:285), the disorder usually manifests itself in adolescence or early adulthood. Clinical depression co-occurs with OCD (Crawford, 2005:191), and studies have found that approximately 25% of OCD patients meet criteria for a major depressive episode. Left untreated, the symptoms of OCD can lead to the development of depression (Crawford, 2005:191).

- *Post-Traumatic Stress Disorder* (PTSD) – (cf. Lyles *et al.* 2005:387; Plutchik, 2003:301)

  The DSM-IV-TR (APA, 2000:429) defines *post-traumatic stress disorder* as the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma. According to Lyles *et al.* (2005:388), 75% of people will experience some type of severe trauma in their lifetime, and 20% of those will develop PTSD. PTSD can follow an exposure to a traumatic event, such as a sexual or physical assault, witnessing a death, the unexpected death of a loved one, or natural disaster (cf. Sadock & Sadock, 2003:623; Öhman, 2004:575). Middleton (2004:287) is of opinion that PTSD usually occurs within three months of the trauma occurring, but sometimes the onset is delayed (cf. Strong, 2003:18). There are three main symptoms associated with PTSD: "reliving" of the traumatic event (such as flashbacks and nightmares); avoidance behaviours (such as avoiding places related to the trauma) and emotional numbing (detachment from others); and physiological arousal such as difficulty sleeping, irritability or poor concentration (cf. Middleton, 2004:287). Middleton (2004:287; cf. Sadock & Sadock, 2003:627; Strong, 2003:18) explains that PTSD occurs at all ages, although in children the disorder might present with generalised nightmares, and a feeling that they will not live to be adults.

- *Generalised Anxiety Disorder* (GAD)

  The DSM-IV-TR (APA, 2000:429) describes *generalised anxiety disorder* as being characterised by at least six months of persistent and excessive anxiety and worry.

  GAD is characterised by excessive, unrealistic worry that lasts six months or more; in adults the anxiety may focus on issues such as health, money, or career (ADAA, 2006). GAD (together with social phobia) is one of the more common anxiety disorders (Middleton, 2004:287; cf. Sadock & Sadock, 2003:632). Middleton (2004:287)

indicates that more than half the people suffering from this disorder have had high anxiety levels since childhood. In addition to chronic worry, GAD symptoms include trembling, muscular aches, insomnia, abdominal upsets, dizziness, and irritability (ADAA, 2006; cf. Sadock & Sadock, 2003:633). As in severe cases of depression, the memory may become temporarily impaired (Strong, 2003:17). Specific information may not be able to be retrieved or the information may never have made it into the memory in the first place.

- *Phobias* (including Social Phobia, also called Social Anxiety Disorder – SAD)

  Phobia comes from the Greek word for "in dread of" (Strong, 2003:11). The term *phobia* refers to an excessive fear of a specific object, circumstance or situation and usually leads to conscious avoidance of the feared subject, activity or situation (Sadock & Sadock, 2003:609; cf. ADAA, 2006). Different types of phobia are discussed below:

  Social Anxiety Disorder (SAD): According to the DSM-IV-TR (APA, 2000:429) *social phobia* is characterised by clinically significant anxiety provoked by exposure to certain types of social or performance situations, often leading to avoidance behaviour. SAD is characterised by extreme anxiety about being judged by others or behaving in a way that might cause embarrassment or ridicule (cf. Plutchik, 2003:316; Sadock & Sadock, 2003:609). Middleton (2004:285) argues that the fear centres around unobservable events, such as negative evaluation. This intense anxiety may lead to avoidance behaviour. According to Plutchik (2003:316; cf. Faw, 2004:147; Strong, 2003:12), the fear sometimes is limited to such things as being unable to speak in a group, or to use public washrooms, or to write in front of people without trembling. In other cases, the fear may be general and involve many of the above signs in the same person. Physical symptoms associated with this disorder include heart palpitations, faintness, blushing and profuse sweating (ADAA, 2006). Social phobia frequently begins in

childhood or adolescence (Strong, 2003:12). The sufferers from social phobia realise their concerns are irrational but, without help, it usually means little in the way they react to their triggers.

Specific phobias: The DSM-IV-TR (APA, 2000:429) describes *specific phobia* as being characterised by clinically significant anxiety provoked by exposure to a specific feared object or situation, often leading to avoidance behaviour. People with specific phobias suffer from an intense fear reaction to a specific object or situation (such as spiders, dogs, or heights); the level of fear is usually inappropriate to the situation, and is recognised by the sufferer as being irrational (cf. Sadock & Sadock, 2003:609). This inordinate fear can lead to the avoidance of common, everyday situations. Middleton (2004:284) reports that people with such phobias are usually free of symptoms unless they are in or anticipate entering the phobic situation.

2.4.4 Causes of anxiety

According to ADAA (2006; cf. HP, 2006; Nevid *et al.* 2003:173), experts believe that anxiety disorders are caused by a combination of *biological* and *environmental* factors, much like physical disorders such as heart disease or diabetes. The mechanisms in the body, which regulate the amount of stress and the times one feels it, play a large role in the anxiety illnesses (Strong, 2003:1). Anxiety disorders are real, serious, and treatable. According to ADAA (2006; cf. Amen & Routh, 2003:21; Plutchik, 2003:318; Hart & Weber, 2005:168), anxiety disorders may develop from a complex set of risk factors, including *genetics*, *brain chemistry*, *personality*, and *life events*.

Strong (2003:28) lists the following causes for *panic attacks*:

- Heredity. Either the anxiety illness itself is passed on or, at the very least, the predisposition for it is in the genes.
- An unhealthy atmosphere in the family home during childhood may be behind the anxiety.
- Very long periods of stress can cause anxiety.
- Medical problems may be at the root of or mimic some anxiety disorders.
- The biopsychosocial model of anxiety disorders states that, while a chemical imbalance may be a contributing factor in some anxiety cases, there are other interacting elements which must be considered such as genetics, certain stressful situations or thoughts, medical problems which can aggravate anxiety, etc.

Once a person has been "sensitised" to anxiety, it is fairly easy for certain things to trigger an increase in anxiety levels (Strong, 2003:29). These triggers are numerous and include having to repress feelings, negative self-talk, remembering stressful or unhappy events, a slight choking feeling from swallowing food or pills, height, a feeling of being trapped in an elevator or bank line-up, etc. The panic attack itself may occur even from the fear of an attack itself or without the person realising what the trigger is, if any.

According to Strong (2003:35), the roots of *generalised anxiety disorder* (GAD) may lie in one or more of:

- fear of failure;
- fear of not being able to cope with demands;
- fear of rejection or abandonment;
- fear of death or illness;
- a genetic disposition;
- patterns of coping (or not coping) as learned in the early family setting;
- being under stress for a long period of time; or
- none of the above.

Some events that can produce *post-traumatic stress disorder* include (Strong, 2003:48):

- being in a serious car accident;
- seeing a neighbour's dog being run over;
- a lingering terminal illness in a loved one;
- a house fire;
- seeing parts of one's friend's body flying in various directions when he steps on a land mine;
- sexual abuse as a child;
- rape;
- a mugging;
- a kidnapping;
- a near drowning;
- being involved in or seeing a catastrophic event; and
- a sudden realisation that there is extreme danger and one is helpless to do anything about it.

When one considers the onset and cause of anxiety disorders, the findings are different for the subtypes of anxiety (Plutchik, 2003:318). Social phobias, for example, tend to appear first in childhood or adolescence and rarely thereafter. The onset of panic disorders and agoraphobias tends to occur in later adolescence or early adulthood, with an average age of onset of about 26 years.

2.4.5 Symptoms of anxiety

According to Minirth and Meier (2002:170), the anxious individual may be hyper-alert, irritable, fidgety and over-dependent. He may talk too much and have difficulty falling asleep. His concentration may be impaired and his memory poor. He may be immobilised by his anxiety. The anxious individual may experience excessive perspiration, muscle tension, headaches, a quivering voice, sighing respirations, episodes of hyperventilation, abdominal

pain, nausea, diarrhoea, "butterflies" in his stomach, high blood pressure, a rapid heartbeat, fainting episodes, frequent urination, impotence, or frigidity (Minirth & Meier, 2002:170; cf. Plutchik, 2003:314; Öhman, 2004:575; ADAA, 2006).

Peripheral manifestations of anxiety, according to Sadock and Sadock (2003:592; cf. Strong, 2003:19), are:

- Diarrhoea
- Dizziness, light-headedness
- Hyperhidrosis
- Hyperreflexia
- Hypertension
- Palpitations
- Pupillary mydriasis
- Restlessness (e.g. pacing)
- Syncope
- Tachycardia
- Tingling in the extremities
- Tremors
- Upset stomach ("butterflies")
- Urinary frequency, hesitancy, urgency.

Sadock and Sadock (2003:592; cf. Hart & Weber, 2005:168; Öhman, 2004:574) have found that the experience of anxiety has two components: the awareness of the physiological sensations (such as palpitations and sweating) and the awareness of being nervous or frightened. A feeling of shame may increase anxiety – others will recognise that one is frightened (Fitzpatrick, 2002:20). In addition to motor and visceral effects (mentioned above), anxiety affects *thinking*, *perception*, and *learning*. Sadock and Sadock (2003:592) also explain that it tends to produce confusion and distortions of perception, not only of time and space but also of persons and the meanings of events. These

distortions can interfere with learning by lowering concentration, reducing recall, and impairing the ability to relate one item with another, that is, to make associations.

An important aspect of emotions is their effect on the selectivity of attention (Sadock & Sadock, 2003:593; *cf.* Mitchell, 2004:136). Anxious persons are apt to select certain things in their environment and overlook others in their effort to prove that they are justified in considering the situation frightening. If they falsely justify their fear, they augment their anxieties by the selective response and set up a vicious circle of anxiety, distorted perception, and increased anxiety (cf. Fitzpatrick, 2002:20). If, alternatively, they falsely reassure themselves by selective thinking, appropriate anxiety may be reduced, and they may fail to take necessary precautions (Sadock & Sadock, 2003:593).

2.4.6 Treatments for anxiety disorders (see 2.3.8)

Fortunately, the vast majority of people with an anxiety disorder can be helped with the right professional care. Anxiety disorders are highly treatable, yet only about one-third of those suffering from an anxiety disorder receive treatment (ADAA, 2006). The treatments that work best for depression also combat anxiety (Marano, 2003; cf. Nevid *et al.*, 2003:183). Marano (2003; cf. Hart & Weber, 2005:171) argues that cognitive-behavioural therapy (CBT) gets at response patterns central to both conditions. The drugs most commonly used against depression, the SSRIs, or selective serotonin reuptake inhibitors, have also been proved effective against an array of anxiety disorders, from social phobia to panic and post-traumatic stress disorder (PTSD). Which drug a patient should get is based more on what he or she can tolerate rather than on symptoms. ADAA (2006; cf. Hart & Weber, 2005:162) reports that a combination therapies are often utilised.

Alone or in combination, *psychotherapy*, *cognitive-behavioural* therapy, and *medication* therapy are effective treatments (ADAA, 2006; cf. Hart & Weber, 2005:175; Plutchik, 2003:321). There are no guarantees, and success and

treatment rates vary with the individual. Furthermore, patients with an anxiety disorder sometimes suffer from clinical *depression* and substance abuse, further complicating proper diagnosis and prolonging treatment (ADAA, 2006).

According to ADAA (2006), *psycho-social* treatments used in the treatment of anxiety disorders include cognitive behavioural therapy (CBT), exposure therapy, anxiety management and relaxation therapies, and psychotherapy.

A number of these therapies are listed below:

Behaviour Therapy

The goal of Behaviour Therapy, according to ADAA (2006), is to modify and gain control over unwanted behaviour. The individual learns to cope with difficult situations, often through controlled exposure to them. Desensitising occurs by being in the situation (Strong, 2003:94). This kind of therapy gives the individual a sense of having control over their life.

Cognitive Therapy

The goal of Cognitive Therapy is to change unproductive or harmful thought patterns. The individual examines his feelings and learns to separate realistic from unrealistic thoughts (ADAA, 2006, cf. Burns, 2000:12). The negative self-talk is replaced by positive self-talk (Strong, 2003:94). As with Behaviour Therapy, the individual is actively involved in his own recovery and has a sense of control (ADAA, 2006).

Cognitive-Behaviour Therapy (CBT)

Many therapists use a combination of Cognitive and Behaviour Therapies; this is often referred to as CBT (ADAA, 2006; cf. Hart & Weber, 2005:163; Strong, 2003:93). According to Middleton (2004:294), CBT is based on the idea that a person's feelings and behaviours in any given situation are largely determined by his or her *interpretation of* and *assumptions about* the experience. One of the benefits of these types of

therapies is that the patient learns recovery skills that are useful for a lifetime (ADAA, 2006).

Relaxation Techniques

Relaxation Techniques help individuals develop the ability to more effectively cope with the stresses that contribute to anxiety, as well as with some of the physical symptoms of anxiety (ADAA, 2006; cf. Middleton, 2004:306). The techniques taught include breathing re-training and exercise.

Medication can be very useful in the treatment of anxiety disorders, and it is often used in conjunction with one or more of the therapies mentioned above (ADAA, 2006; cf. Nevid *et al.*, 2003:183; Marano, 2003). *Drugs* used to treat anxiety disorders include selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants, benzodiazepines, beta-blockers, and monoamine oxidase inhibitors (MAOIs). Medication is effective for many people and can be either a short-term or long-term treatment option, depending on the individual (ADAA, 2006). Middleton (2004:311) points out that because some of the anxiety disorders (phobias, obsessive-compulsive disorders, panic disorders) are more responsive to antidepressant medication, it has been suggested that these might be more closely related biochemically to depression than to generalised anxiety.

Strong (2003:94-97) lists additional therapies for the treatment of anxiety:

Interceptive Exposure

An individual purposely brings on bodily sensations that are similar to those experienced during panic episodes so that they have the opportunity to learn they are not dangerous (rapid breathing to bring on light-headedness and dry mouth, wearing a tie tightly around the neck to bring on a tight throat, etc.).

Naturalistic Exposure

This therapy is used for the same purpose as interceptive exposure. Examples include drinking caffeinated coffee or running up stairs to bring on rapid heart rate, etc.

Support Therapy

This primarily involves talking about the problem or situation and suggestions being made.

Prayer

This has been very helpful for many anxiety sufferers.

Visualisation

This involves seeing oneself doing it before actually doing it.

Virtual reality

Computer-generated graphics allow a person to "walk" through a place or a situation which causes anxiety prior to actually doing it.

Developing coping strategies

A person learns what to do when the anxiety level is very high. This "arsenal" is extremely important in keeping the anxiety under control and not letting it "blow out".

Diet

Some people find that certain foods, such as sugar and caffeine, can increase their anxiety level.

Exercise

Regular exercise of even 10 to 20 minutes a day has been shown to be helpful in reducing anxiety as well as depression.

In conclusion, millions of people are victims of anxiety attacks. Anxieties and fear are persistent and overwhelming, and can interfere with daily life. Once a person has been "sensitised" to anxiety, it is fairly easy for certain things to trigger an increase in anxiety levels.

Anxiety disorders are caused by a combination of *biological* and *environmental* factors. An understanding of anxiety is essential for the treatment of depression since depression very rarely occurs without associated fear or anxiety.

The vast majority of people with an anxiety disorder can be helped with the right professional care, yet only about one-third of those suffering from an anxiety disorder receive treatment. Alone or in combination, *psychotherapy*, *cognitive-behavioural* therapy, and *medication* therapy are effective treatments.

2.5 DEPRESSION AND ANXIETY TOGETHER

As explained above (2.2), depression and anxiety usually go hand in hand. It is estimated that 70% of those with anxiety disorder will develop depression (Strong, 2003:117). Different groups of people are at risk for combined anxiety and depression:

- Marano (2003) reports that there definitely is a *family component*: "Looking at the family history of a person who presents with either primary anxiety or depression provides a clue to whether he or she will end up with both." according to Joseph Himle, Ph.D., associate director of the anxiety disorders unit at University of Michigan.
- The *nature* of the anxiety disorder also has an influence. Obsessive-compulsive disorder, panic disorder and social phobia are particularly associated with depression. Specific phobias are less so.
- *Age* plays a role, too. A person who develops an anxiety disorder for the first time after age 40 is likely also to have depression, according to

> Himle: "Someone who develops panic attacks for the first time at age 50 often has a history of depression or is experiencing depression at the same time." (Marano, 2003).

According to Marano (2003), anxiety usually *precedes* depression, typically by several years. Currently, the average age of onset of any anxiety disorder is late childhood/early adolescence, whereas the onset of depression is usually in the mid 20's (cf. Valfre, 2001:241; 2.3.5). Yapko observes that a young person is not likely to outgrow anxiety unless treated and taught cognitive skills. However, the aggressive treatment of the anxiety when it appears can prevent the subsequent development of depression (cf. Marano, 2003).

Furthermore, anxiety and depression share an avoidant coping style. Marano (2003) explains that sufferers avoid what they *fear* instead of developing the skills to handle the kinds of situations that make them uncomfortable. Often enough a lack of social skills is at the root – the link between social phobia and depression is dramatic (Marano, 2003). Treatment of these mood disorders seldom hinges on which disorder came first (Marano, 2003). In practice, treatment is targeted at depression and anxiety simultaneously: "There's increasing interest in treating both disorders at the same time." (Himle, as quoted by Marano, 2003). *Cognitive behavioural therapy* (CBT) is particularly attractive because it has applications to both (cf. 2.3.8; 2.4.6). Studies show that it is effective against both. However, sometimes the depression is so incapacitating that it has to be tackled first. Marano (2003) argues that depression, for example, typically interferes with exposure therapy for anxiety, in which people confront in a graduated way situations they avoid because they give rise to overwhelming fear.

According to Marano (2003), medication and CBT are equally effective in reducing anxiety/depression. But CBT is better at preventing relapse, and it creates greater patient satisfaction (cf. 2.3.9). Treatment averages 12 to 15 weeks, and patients can expect to see significant improvement by six weeks.

2.6 MOOD AND ANXIETY DISORDERS AND SUICIDE

According to Nevid *et al.* (2003:265), mood disorders are often linked to suicide. Depression and co-morbid anxiety is so widespread it is considered the common cold of psychiatric disturbances (Burns, 2000:9; cf. Solomon, 1998; 2.2). However, there is a grim difference between depression and a cold: depression can kill you. Studies of the suicide rate indicate that suicide has been on a shocking increase in recent years. This escalating death rate has occurred in spite of the billions of antidepressant drugs and tranquilisers that have been dispensed during the past several decades (Burns, 2000:9).

Depression and co-morbid anxiety can make even the most successful, productive and creative people in the world feel worthless (Condrell, s.a.). When people become severely depressed, they give up hope that their life will ever improve (Koenig, 1999:131). Ohlschlager *et al.* (2005:334) observe that in the distorted and pain-dominated judgement of the sufferer, suicide may be the most logical and effective choice to resolve what is perceived as an impossible problem. For some, the pain may be so severe that they choose to end their lives, and about 15 percent of depressed people actually kill themselves (Condrell, s.a.; cf. Koenig, 1999:131).

Suicide is the extremity of a self-inclined, self-destructive act – whether it be a thought, an expression or an attempt – to take one's own life. The degree of lethality, the motive, the intent and the awareness of possible consequences vary (Jarvis & Middleton, 2004:348; cf. Ohlschlager *et al.*, 2005:335). According to Koenig (1999:124; cf. Zohar & Marshall, 2001:182) suicide is almost always an act of *despair* stemming from depression, which in turn is often engendered by unbearable stress. Zuckerman (2000:72) suggests that *hopelessness* seems to be the crucial factor in suicide, not depression. In addition, the grim progression from stress to depression to suicide among adolescents and young adults has accelerated in the last three decades (cf. Burns, 2000:9).

The major complication of depression is suicide (Meier, Minirth *et al.*, 1997:278; Faw, 2004:148). Plutchik (2003:323) identified 62 variables that are possible risk factors for suicidal behaviour and he lists depression first. According to Jarvis and Middleton (2004:35), early recovery stages of depression *increase* the risk of another suicide attempt, as energy and drive begin to return to the person. DFAQ (2006) reports that men are less likely to admit to depression, and doctors are less likely to suspect it in men (cf. 2.3.5). The rate of suicide in men is four times that of women, though more women attempt it. In fact, after age 70, the rate of suicide among men rises, reaching a peak after age 85 (DFAQ, 2006; cf. Tan & Lyles, 2005:158).

It is well known that individuals with severe depression and bipolar disorder have a high risk for suicide (Tan & Ortberg, 2004:44). Depression is the leading cause of suicide, which claims 30 000 lives each year in the United States (Bear, *et al.*, 2001:19). According to Caruso (s.a.), a research project at the Nelson Mandela School of Medicine in South Africa indicates that suicide is on the rise in the country and that children as young as 10 are dying by suicide. Sookha (2005) agrees that suicide is a growing problem in South Africa and points out that every hour, one person commits suicide and the numbers continue to rise with more than 20 to 40 attempts per hour. According to Jarvis and Middleton (2004:348), a 2002 report stated that suicide accounted for 7,7% of all non-natural deaths in South Africa.

According to Cronkite (1999), within five years of suffering a major depression, an estimated 25% of sufferers try to kill themselves. An estimated 2-15% of persons who have been diagnosed with major depression die by suicide, according to the National Strategy for Suicide Prevention (Condrell, s.a) and the federal government of the United States estimates that about 60% of people who commit suicide have suffered from a mood disorder (Nevid *et al.*, 2003:256). Dr Collins (as quoted by Tan & Ortberg, 2004:44; cf. Tan & Lyles, 2005:158) has pointed out that the rise in suicide in the past thirty years or so can be described as an "epidemic", with suicide and suicide attempts apparently increasing among children, prisoners, the elderly, young

adults, and particularly teenagers (cf. Burns, 2000:9). Christians are also affected. According to Fast and Preston (2004:33), suicidal thoughts and impulses sometimes arise from feelings of *self-hatred* and *guilt*, although most times, the urge to kill oneself is born of the desire to just stop suffering.

According to Kennedy and Charles (as quoted by Tan and Ortberg, 2004:44), it is important to note the following factors that are associated with a higher risk or potential for suicide (cf. Jarvis & Middleton, 2004:349; Tan & Lyles, 2005:158):

a. Age and sex: men, especially those over sixty-five.
b. Symptoms: depression, feelings of hopelessness, insomnia or difficulty sleeping, or alcoholism.
c. Stress: severe stress.
d. Acute versus chronic aspects: sudden or acute onset of particular symptoms means a higher suicide risk.
e. Having a suicidal plan: especially if there is a suicidal plan that is lethal, organised, and detailed.
f. Lack of resources: no family or friends.
g. Prior suicidal behaviour: past history of suicidal attempts, especially if many in number.
h. Medical status: presence of chronic, debilitating illness.
i. Communication aspects: the person has no outlet or has been rejected by others (this means it is important to take suicide notes seriously).
j. Reaction of significant others: others punish or reject the person.

The risk factors for suicide according to Zuckerman (2000:199) are the following:

a. Psychiatric status.
b. Psychological symptoms.
c. Demographics.
d. Feasible plan of action.

e. Prior suicidal behaviours.
f. Social isolation.
g. Stressors.
h. Other risk-increasing variables.

Cronkite (1999) stresses that it is a myth that people who talk about suicide, do not attempt it. She points out that many people announce their intention before their suicide attempts (cf. Nevid *et al.*, 2003:262; Reinecke, 2001:177). According to Fast and Preston (2004:33), the suicide rate among those with *bipolar disorder* is quite high, and thus any suicide threats must be taken seriously.

An interesting approach to the evaluation of suicidal intention – based on the clinical theory of Robert Firestone – is the *Firestone Voice Scale for Self-Destructive Behaviour (FAST)*, which ranks thoughts on an 11-point scale from self-critical to cynical, vicious, urging substance abuse, withdrawal, self-injury, and suicide (Zuckerman, 2000:73). This approach, which integrates cognitive and psychodynamic concepts, assesses the levels of self-destructive thoughts a person is experiencing, along a specific *Continuum of Negative Thought Patterns*. The continuum begins with self-critical thoughts of everyday life (Level 1), progresses to self-abusive thoughts and vicious self-accusations (Level 5), then on to those leading to addictive behaviour or substance abuse (Level 6), and finally to injunctions to carry out a suicidal plan (Level 11). *FAST* scores indicate areas in which the client is experiencing the greatest degree of distress. It will also serve as a brief pre- and post-therapy measure (GA, 2004).

Reinecke (2001:200) lists the following guidelines for helping someone with suicidal intentions in her model for self-destructive behaviour:

- No suicide threat may ever be ignored.
- The role of religion and faith in the life of the suicidal person should not be underestimated.

- Certain guidelines concerning questioning should be followed.
- Questions concerning the person's view about the future, his/her view about death, the here-after, and heaven and hell are important.
- Special attention should be given to situations that, according to human standards, justify suicide.
- In compliance of the person's breakpoint-circumstances, a discussion of applicable Scriptures and a prayer program is particularly significant.

2.7 MOOD AND ANXIETY DISORDERS AND SELF-HARM

According to Reinecke (2001:205), self-destructive behaviour and suicide/suicidal intentions are synonyms, and a combination of factors may lead to it. Fast and Preston (2004:34; cf. Coetzer, 2005b:52) observe that self-harm can take several forms: severe substance abuse (that is, endangering one's health or safety with drinking or using drugs), very reckless behaviour (e.g. dangerous driving), binge eating (including overeating and purging by vomiting or by using laxatives), and self-mutilation (e.g. burning, hitting, cutting, excessive scratching, using harsh abrasives on skin or scalp, poking sharp objects into the flesh, head banging, pulling out hair or eyebrows for non-cosmetic purposes, inserting objects into body orifices, excessive fasting, self-surgery, excessive tattooing, or refusing needed medication).

According to Sadock and Sadock (2003:793), persons who repeatedly cut themselves or do damage to their bodies may do so in a compulsive manner. Freeman (2003) has found that for many girls – and less commonly boys – self-harm is a normal, almost banal response to emotional pain. According to Reinecke (2001:199), problems concerning emotions like rejection, anger, bitterness, forgiveness, and hope versus hopelessness are typically found in people with self-destructive behaviour.

Most often, self-harm follows a history of protracted childhood traumas (such as physical and/or sexual abuse), not a single exposure (Coetzer, 2005b:53).

The person harms himself in response to overwhelming, dissociated pain. Coetzer (2005b:53 & 144) identifies a number of possible reasons for this:

- It expresses pain that cannot be verbalised.
- It attempts to convert emotional pain to physical pain.
- It paradoxically relieves pain.
- It is a way to feel alive.
- It provides an illusory sense of power, a sense of mastery and control of pain.
- It is a way to contain aggressive tendencies and pain.
- It vents powerful emotions that cannot be vented directly.
- It makes the body unattractive to spare further abuse.
- It is consistent with one's view of self.

Some people who suffer from *bipolar disorder* experience a rare physical anomaly (Fast & Preston, 2004:34). When they inflict physical pain on themselves (e.g. burning oneself with a cigarette), they feel an almost instantaneous relief from psychological/emotional pain (cf. Coetzer, 2005b:53). Fast and Preston (2004:34) also remark that this cessation of emotional suffering typically lasts for about an hour. In addition, they actually *feel* no physical pain from the burn. This very peculiar phenomenon is seen primarily in those who have *bipolar disorder* and co-occurring *borderline personality disorder*. Some people also experience a diminution in suffering from bingeing or reckless behaviour.

According to Fast and Preston (2004:34), it is important to know that most times self-harm behaviour is not motivated by the desire to suffer or to punish oneself; rather it reflects desperate attempts to reduce suffering (although, obviously, such attempts can backfire and cause serious injury or death). Welch (2004:32) reports that self-injurers *can* be suicidal, but there is a difference between the two behaviours. Those who purposefully cut an artery are trying to kill themselves: they want life to be over. In contrast, cutters tend to be more careful about where or how deeply they cut: they just want to feel

better. Self-abusers typically want to live; they simply do not know how to live with turbulent emotions.

The chapter thus far focused on the psychiatrical, psychological and medical perspectives of mood and anxiety disorders. A definition of each, the different types of depression and anxiety, its causes and symptoms were described and the different treatment approaches for each were discussed. Suicide and self-harm were discussed as they pertain to mood and anxiety disorders. The remainder of the chapter will be devoted to the findings from the qualitative empirical research on how the experimental group experienced the healing power of faith in dealing with their mood and anxiety disorders.

2.8 FINDINGS OF THE SEMI-STRUCTURED INTERVIEWS

2.8.1 Introduction

The term *qualitative research* encompasses several approaches that are in some respects quite different from another. Yet, according to Leedy and Ormrod (2005:133), all qualitative approaches have two things in common:

- Firstly, they focus on phenomena that occur in natural settings – that is, in the "real world".
- Secondly, they involve studying those phenomena in all their complexity.

Qualitative researchers rarely try to simplify what they observe. Instead, they recognise that the issue they are studying has many dimensions and layers, and so they try to portray the issue in its multifaceted form (Leedy & Ormrod, 2005:133). According to Leedy and Ormrod (2005:134) qualitative research studies typically serve one or more of the following purposes:

- *Description* – They can reveal the nature of certain situations, settings, processes, relationships, systems, or people.
- *Interpretation* – They enable a researcher to (a) gain new insights about a particular phenomenon, (b) develop new concepts or theoretical perspectives about the phenomenon, and/or (c) discover the problems that exist within the phenomenon.
- *Verification* – They allow a researcher to test the validity of certain assumptions, claims, theories, or generalisations within real-world contexts.
- *Evaluation* – They provide a means through which a researcher can judge the effectiveness of particular policies, practices, or innovations.

For the purposes of this study, *case studies* – as one common qualitative research design – was employed. In a case study, a particular individual, programme or event is studied in depth for a defined period of time by means of observations, interviews, documents, past records, and audiovisual materials (Leedy & Ormrod, 2005:133). In this study, semi-structured interviews were conducted with five counselees struggling with *mood and anxiety disorders* in order to gather information about the *role that faith has played* in their emotional struggles. The counselees have all been seen for counselling over a period of at least six months and full documentation is available about the counselee's counselling sessions. The interview findings will be structured as follows:

1. Presentation of the problem.
2. Psychological/medical evaluation and diagnosis.
3. Counselling process.
4. Result after counselling.

2.8.2 Interview findings

2.8.2.1 Counselee A

a. Presentation of the problem

Counselee A; female, 32 years of age and married for 5 years; came for counselling for her *mild depression*. A successful businesswoman and mother of two was struggling with feelings of incompetence, worthlessness, restlessness, loss of hope, irritability, and fatigue. A perfectionist and priding herself on her good intellect and memory, Counselee A was struggling with a poor memory and finding it hard to make decisions. Getting through her daily chores was also getting more difficult.

Counselee A, a devout Christian who believes that Jesus Christ is her Saviour, was struggling with wrong perceptions about God and could not understand why her feelings were in such disarray. As an intellectually astute women, Counselee A was trying to "think herself" out of her depression.

b. Psychological/medical evaluation and diagnosis

Counselee A presented with the following *symptoms* associated with depression:

- Incompetence.
- Worthlessness.
- Restlessness.
- Loss of hope.
- Irritability.
- Fatigue.
- Wrong perceptions about God.

Counselee A had already visited her general practitioner and was diagnosed with *mild depression*.

c. Counselling process

The following steps were followed with **all the counselees** before addressing each of their individual concerns:

- The counselee was requested to identify his/her own as well as the family's history of depression.
- A graphic timeline was utilised to help the counselee identify the pattern of his/her depression symptoms.
- The counselee was questioned about current day-to-day functioning regarding depression symptoms (e.g., mood/affect, sleep, appetite, suicidal thoughts, guilt, delusion, etc.).
- The Counselee was provided with sleeping, eating, and activity logs on which to document current levels of functioning.
- The depth and signs of the counselee's depression was assessed with the Hamilton Rating Scale for depression and the Zung Self Rating Scale for depression (cf. appendix A).
- The counselee was encouraged to share his/her feelings of depression; that is, to identify specific emotions, in order to clarify them and gain insight into the causes of his/her depression.
- The spiritual struggles experienced by the counselee were explored.
- The counselee was educated about the causes and different treatment methods for his/her depression.
- The client was referred to a physician for a complete physical examination to rule out medical etiologies for depression and/or a psychiatrist for medication for their depression and/or anxiety.

In the case of A, the counselling focused on the following issues:

- Wrong perceptions about God.
- Feelings of incompetence and worthlessness.
- Poor memory.
- Attempt to "think" herself out of the depression.

The goal was to renew the counselee's faith in God, restore her self-esteem, teach her techniques to remember important things, and redirect her thinking from herself to Christ. The following Scripture passages were quoted:

- **Romans 12:2** – Renewing of the mind
  Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is – his good, pleasing and perfect will.

- **Proverbs 3:5-6** – Trust in the Lord
  Trust in the Lord with all your heart, and lean not on your own understanding; in all your ways acknowledge him, and he will make your paths straight.

- **Romans 5:1**
  So now, since we have been made right in God's sight by faith in his promises, we can have real peace with him because of what Jesus Christ our Lord has done for us.

The counselee was taught to keep notes when she had to remember important things. That reduces anxiety and gives the counselee a feeling of control.

d. Result after counselling

After several sessions, Counselee A started to *correct her thinking patterns and perspective about God* and realised that God did not change; it was her perceptions that changed. A also reinforced her *trust in God.*

Counselee A came for follow-up sessions three years later, and whilst still struggling with her depression, she admitted that it was her *faith in God that ultimately carried her through* her struggles.

2.8.2.2 Counselee B

a. Presentation of the problem

Counselee B, 50 years of age, came for counselling for *major depressive disorder* and *panic attacks*. He was unemployed and struggled financially, and therefore worried how he was going to make ends meet. His negative thoughts resulted in a stress spiral and generated more stress. He struggled with panic attacks, insomnia, fatigue and an overall loss of interest in life. B knew God was with him everyday, but he felt like his prayers were just hitting the ceiling. God felt very far removed, as if God had forgotten him, and as a result, he spent less and less time praying and reading the Bible.

b. Psychological/medical evaluation and diagnosis

Counselee B displayed the following symptoms:

- Panic attacks.
- Insomnia.
- Change in eating patterns.
- Fatigue.
- Restlessness.
- Loss of interest in life.

Counselee B was tested on the *Hamilton rating scale* and the *Zung self-rating scale*. He was diagnosed with major depression and was referred to a medical practitioner for medication.

c. Counselling process

The following approach was taken to address Counselee B's issues:

- Since Counselee B worried about how to make ends meet, he was taught to take one day at a time, and not to worry about the next day.

  In this regard **Matthew 6:34** was studied:
  Do not worry about tomorrow, for tomorrow will worry about itself. Each day has enough trouble of its own.

- Counselee B was assured that his spiritual struggles was due to his depression and not evidence of spiritual failure. In this regard he was assured that God will not forget anyone.

  Isaiah 49:14-16
  Zion said, "The Lord has forsaken me, the Lord has forgotten me." "Can a mother forget the baby at her breast and have no compassion on the child she has borne? Though she may forget, I will not forget you! See, I have engraved you on the palms of my hands; your walls are ever before me."

- The counselee was reassured of God's unfailing faithfulness and compassion.

  Lamentations 3:32
  Though he brings grief, he will show compassion, so great is his unfailing love.

- Counselee B was guided to renew his relationship with God through daily prayer and Bible study.

- Non-strenuous exercise was recommended.

d. Result after counselling

After about six months of counselling, Counselee B came to the realisation that *God can provide* in all his needs and that through *God's love* and *grace* he could cope with his depression. During the six months of counselling, B found employment, which greatly improved his self-worth and attributed to a decline in the number of his panic attacks.

Counselee B was seen again a year later and he reported that it was his renewed *relationship with God*, which included *studying the Word of God* and *daily prayer*, that alleviated most of his depressive symptoms.

2.8.2.3 Counselee C

a. Presentation of the problem

Counselee C called to make an appointment, saying he was tired of life. When C (43 years old) reported for his first session he said that he could not cope anymore. All the stresses of everyday life had become too much for him to bear. He used to be a very passionate family man, but family had become a burden to him and his business was not doing well at all. He experienced many ups (mania) and downs (depression) associated with the bipolar disorder, but could not cope with the depression anymore.

He is a born-again Christian and believes that God is in ultimate control of a person's life, but could not always understand how a loving God could permit negative things like depression to happen to people, especially to a believer.

b. Psychological/medical evaluation and diagnosis

The following *symptoms* were apparent in Counselee C:

- Stress.
- Insomnia.
- Fatigue.
- Restlessness.
- Agitation.
- Panic attacks.
- Suicidal.
- Anxiety.
- Losing control.

Counselee C suffered from *bipolar I disorder.* He was diagnosed with the disorder five years before and was on chronic medication for the disorder.

c. Counselling process

Counselee C was empowered with the following truths:

- Even believers can suffer from depression.
  The lives of Job (Book of Job and Lamentations) and King David (Psalms) were studied to show the Counselee that even people chosen by God suffered from depression.

- One can put one's hope in God when one is downcast.

  Psalm 42:5-6
  Why are you downcast, O my soul? Why so disturbed within me? Put your hope in God, for I will yet praise him, my Saviour and my God.

- One can call upon the Lord in the day of trouble.

  Psalm 50:15

  Call upon me in the day of trouble; I will deliver you, and you will honour me.

- The faithfulness of God's love and care for his children who are in pain and are suffering.

  James 5:11

  As you know, we consider blessed those who have persevered. You have heard of Job's perseverance and have seen what the Lord finally brought about. The Lord is full of compassion and mercy.

- The peace of God – even in suffering – comes through praying in faith.

  Philippians 4:6-7

  Do not be anxious about anything, but in everything, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus.

d. Result after counselling

After a few counselling sessions Counselee C came to understand that anybody can suffer from depression – even believers. He learned to be content with his mood disorder (Philippians 4:11) and that the testing of his faith produces endurance (James 1:2-3). He found ways to cope with his depression on a daily basis, in particular focusing on the positive things in life. He *studies God's Word regularly* and found *peace and joy* despite his depression.

2.8.2.4 Counselee D

a. Presentation of the problem

Counselee D is a 53 year old divorced woman. She could not sleep, she had lost much weight, and she complained about heart palpitations, sweating excessively and agitation. She had feelings of sadness and crying spells. D also struggled with feelings of guilt because she could not do anything more to save her marriage, and grieved for the lost relationship. She also experienced feelings of worthlessness and low self-esteem. She was very lonely, especially since her two daughters had both left the house.

b. Psychological/medical evaluation and diagnosis

Counselee D presented with the following symptoms:

- Insomnia.
- Weight loss.
- Anxiety: heart palpitations, excessive sweating, agitation.
- Crying spells.
- Feelings of sadness.
- Feelings of guilt.

After being tested on the *Hamilton rating scale* it was apparent that Counselee D manifested with a *major depressive disorder*, together with *generalised anxiety disorder*. A doctor prescribed medication for her depression as well as for her anxiety.

c. Counselling process

The following truths and advice were shared with Counselee D:

- The way out of depression caused by guilt is confession and seeking God's forgiveness. The following Scriptures were used during counselling:

  Psalm 32:5

  Then I acknowledged my sin to you and did not cover up my iniquity. I said, "I will confess my transgressions to the Lord" – and you forgave the guilt of my sin.

  Psalm 32:1-2, 11

  (Then David could sing for joy again). Blessed is he whose transgressions are forgiven, whose sins are covered. Blessed is the man whose sin the Lord does not count against him and in whose spirit is no deceit ... Rejoice in the Lord and be glad, you righteous; sing all you who are upright in heart!

- Counselee D also had to forgive herself.

- Do not be anxious, but pray.

  Philippians 4:6-7 was used to help the Counselee cope with her anxiety (cf. 3.4.2):

  Do not be anxious about anything, but in everything, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus.

- Focusing on God by daily prayer and studying God's Word.

  1 Thessalonians 5:17-18

  Pray continually; give thanks in all circumstances, for this is God's will for you in Christ Jesus.

- Counselee D was urged to join a singles group at her local church to alleviate her feelings of loneliness and to help raise her self-esteem.

d. Result after counselling

Counselee D *asked God's forgiveness* for her failed marriage and *forgave herself*, which alleviated some of her anxiety, because the pressure of the guilt was lifted. With the help of medication together with the counselling D was healed from her mood and anxiety disorders.

Counselee D was seen again two years later. She is now *focusing on God* and the *positive things* in her life. She regularly attends church and joined a singles group, which both helped in raising her self-esteem.

2.8.2.5 Counselee E

a. Presentation of the problem:

This counselee admitted that he was faithful but was seeking help through Eastern meditation. He was suicidal – he had already tried to commit suicide 3 times before. He was angry at his parents because he felt neglected and wanted more attention. He would spread guilt as an attack on his parents. He wanted to be seen as an unhappy person who was suffering because of other people's faults, and someone who should be pitied. He wanted people to feel guilty about his situation, and he used his depression to get his own way or as an excuse not to do certain things.

His sulking and passive aggression showed his anger. He did not speak of his upsets, but closed down and gave people the "silent treatment". He walked around with an angry posture which signalled to others that they should stay away, and acted as if he was really hurt, to induce guilt. Anger was written all over his face. He struggled with feelings of depersonalisation, guilt, weakness and uselessness. He was fatigued, hypochondrial and without motivation. He

had no desire for food, and he had lost a lot of weight. He did not trust people and had feelings of paranoia. He experienced obsessive-compulsive feelings of self-hatred and he wanted to die. His feelings of anxiety included chest pain, difficulty breathing, pins and needles, excessive sweating, feelings of unreality, fear of losing control and visual distortion.

b. Psychological/medical evaluation and diagnosis

Counselee E displayed the following *symptoms*:

- Suicidal.
- Crying.
- Guilt.
- Uselessness.
- Depersonalisation.
- Paranoia.
- Insomnia.
- Fatigued.
- Hypochondrial.
- Weight loss.
- Restless.
- Agitated.
- Anger.
- Anxiety attacks: chest pains, difficulty breathing, pins/needles, sweating, feelings of unreality.

Counselee E was diagnosed with *major depressive disorder* accompanied by *generalised anxiety disorder.* Counselee E was referred for medical intervention.

c. Counselling process

A multi-faceted approach was used to assist Counselee E

- A structured suicide prevention plan was developed to protect the Counselee from further self-harm.

- Counselee E's use of stimulants (street drugs) and depressants (alcohol) was reviewed.

- The counselee was made aware of the fact that concealing sin often leads to depression. If one confesses one's sin and turns from it, one will find mercy. The following Scripture was used in helping Counselee E deal with his sin:

  Proverbs 28:13
  He who conceals his sins does not prosper, but whoever confesses and renounces them finds mercy.

- Counselee E was guided to ask God for forgiveness.

  David was studied in this regard. He was depressed until he repented and was forgiven (Psalm 32:3-4). God readily forgave David when he repented and confessed his sins (Psalm 32:5). Also Psalm 51.

- Counselee E was taught how to handle anger in a godly way, in other words, healthy and assertive ways to express his anger.

  Ephesians 4:26
  "In your anger do not sin". Do not let the sun go down while you are still angry.

James 1:19-20

My dear brothers, take note of this: Everyone should be quick to listen, slow to speak and slow to become angry, for man's anger does not bring about the righteous life that God desires.

- The Counselee was equipped to build a relationship with God through prayerful meditation and studying the Word of God regularly. The Lord's Prayer is a good model (Matthew 6:9-13).

d. Result after counselling

Counselee E admitted his *sin* and *prayed for forgiveness*. He understood that his anger was unjustified and he was making a conscious effort to deal with his anger. He needed follow-up counselling to help him grow *spiritually*. A right relationship with God could help to eliminate the animosity that developed between the counselee and his parents. In addition, regular time alone with God, reading the Bible, praying, and meditating on His Word could help clarify areas in his life that needed attention and could better prepare him to handle his anger and anxiety.

All of the counselees were referred to medical practitioners for medication, which alleviated some of their symptoms. They all needed counselling (holistic faith-based approach – see 5.3) to cope with or alleviate their mood and anxiety disorders.

2.8.3 Summary of the semi-structured interviews

The following table summarises the above interview findings:

Summary of the semi-structured interviews

	Counselee A	Counselee B	Counselee C	Counselee D	Counselee E
Symptoms associated with mood and anxiety disorders and evident in counselee	incompe-tence, worthless-ness, restless-ness, loss of hope, irritability, fatigue, wrong percep-tions about God.	panic attacks, insomnia, change in eating patterns, fatigue, restless-ness, loss of interest in life.	stress, insomnia, fatigue, restless-ness, agitated, panic attacks, suicidal, anxiety, loss of control.	insomnia, weight loss, anxiety, crying spells, heart palpitat-ions, excessive sweating, agitation, feelings of sadness, feelings of guilt.	suicidal, crying, guilt, use-lessness, depersona-lisation, paranoia, insomnia, fatigued, hypochon-drial, loss of weight restless, agitated, anger, anxiety attacks, chest pains, difficulty breathing, pins & needles, sweating, feelings of unreality, losing control, visual distortion.

	Counselee A	Counselee B	Counselee C	Counselee D	Counselee E
Cause of counselees' depression	Chemical imbalance, incorrect thinking patterns.	Chemical imbalance, negative stress spiral.	Chemical imbalance, head injury caused behaviour-al change.	Chemical imbalance, guilt, thinking pattern changed.	Chemical imbalance, sin.
Role faith played in helping Counselees to heal and/or cope	Changed her thinking patterns and perspect-ive of God and reinforced her trust in God.	Came to the realisation that God can provide in all his needs and that through God's love and grace he could cope with his depress-ion.	Now under-stands that anybody can suffer from depression – even believers. He studies God's Word regularly and found peace and joy despite his depress-ion.	Asked God's forgive-ness for her failed marriage and forgave herself, which alleviated some of her anxiety. She is now focusing on God and the positive things in life.	He admitted his sin and prayed for forgive-ness. He under-stands that his anger is unjustified and is making a conscious effort to deal with his anger. He needs follow-up counselling to help him grow spiritually.

Table 2.7

2.8.4 Conclusions from the semi-structured interviews

After studying the above cases, it can be concluded that pastoral counselling and especially the *holistic faith-based model* (to be discussed in Chapter 5), can effectively be used to help people with mood and anxiety disorders to overcome and/or cope with their emotional problems. It is clear that *faith* has played a significant role in the counselees' recovery from or ability to cope with their mood and anxiety disorders.

2.9 PRELIMINARY CONCLUSION TO CHAPTER TWO

Chapter two explored the viewpoints of the scientific disciplines of psychiatry, psychology, and medicine regarding mood and anxiety disorders, specifically depression and anxiety, and the role these play in people's lives. Brief conclusions from this study are summarised below.

In the world of mental health care, *anxiety* and *depression* are regarded as two distinct disorders. However, many people suffer from both conditions. In fact, most *mood disorders* present as a combination of anxiety and depression. Depression and co-morbid anxiety is so widespread that they are considered the most common psychiatric disturbances. These disorders can make even the most successful, productive and creative people in the world feel worthless. The derangement of emotions is what leads to the profound pain and much of the disability experienced in mental illness (cf. 2.2).

Depression seems to be affecting more and more people. People born during the past three decades are three to ten times more likely to become *depressed* than those born in previous generations. The suicide rate has also been on a shocking increase in recent years. This escalating death rate has occurred in spite of the billions of antidepressant drugs and tranquilisers that have been dispensed during the past several decades (cf. 2.2).

Depression is a mood in which a person feels extreme sadness, withdraws socially, feels guilty and expresses self-deprecating thoughts. Depression is a complex condition to handle or with which to cope. However, understanding depression is the first step toward effective coping. It is not unitary or homogeneous, but heterogeneous and refers to *different* types or kinds of depression with different risk factors involved (cf. 2.3.1; 2.3.2).

There are a number of possible causes of depression, with various authors emphasising different causes, depending on their theoretical viewpoints and models of depression. Psychoanalytical theories see mood disorders as anger turned inward. Behaviourists view depression as a group of learned responses, whereas social theorists consider depression to be the result of faulty social interactions (cf. 2.3.3).

Medical practitioners believe there is a *biological base* for mood disorders. Like most other mental illnesses, mood disorders reflect the altered functioning of many parts of the brain at the same time. Areas of the brain that play an important role in the production of emotions include the reticular formation, the limbic system, and the cerebral cortex (cf. 2.3.3).

Childhood abuse and neglect, in addition to genetic factors, are also known to put people at risk for developing mood and anxiety disorders. Very often, a combination of genetic, psychological, and environmental factors is involved in the onset of a depressive disorder (cf. 2.3.3).

Some people are more at risk for depression than others. Not only is depression on the rise; some researchers feel that people are becoming depressed at earlier stages than in previous generations. Without treatment, depressions recur in 50% of cases, and after three or more episodes, the odds of recurrence increase to more than 70%. Individuals with severe depression and bipolar disorder have a high risk for suicide (cf. 2.3.5).

A number of highly effective treatments for depression are available, although they present many treatment challenges. Treatments include (cf. 2.3.8):

- Psychotherapies.
- Electroconvulsive therapy.
- Drug therapies.

Anxiety can be defined as an emotion associated with some type of internal or external threat to physical or emotional well-being. It is accompanied by a sense of fear or worry about the future, whether in response to a distinct event, or to no event in particular. It may include feelings of physical restlessness and tremulousness. Experts believe that anxiety disorders are caused by a combination of *biological* and *environmental* factors. The mechanisms in the body which regulate the amount of stress and the times one feels it, play an important role in the anxiety illnesses (cf. 2.4.1; 2.4.4).

Most people experience a certain amount of anxiety and fear in their life, and it is a normal part of living. For millions, however, anxieties and fear are persistent and overwhelming, and can interfere with daily life. Anxiety disorders are the most common psychiatric illnesses affecting both children and adults. *Anxiety disorders* are generally classified as follows: Panic Disorders, Obsessive Compulsive Disorder, Post-traumatic Stress Disorder, Generalised Anxiety Disorder and Phobias. The anxious individual may be hyper-alert, irritable, fidgety and over-dependent. They may talk too much and have difficulty falling asleep. Their concentration may be impaired and their memory poor, and they may be immobilised by their anxiety. Anxious individuals may experience excessive perspiration, muscle tension, headaches, a quivering voice, sighing respirations, episodes of hyperventilation, abdominal pain, nausea, diarrhoea, "butterflies" in their stomach, high blood pressure, a rapid heartbeat, fainting episodes, frequent urination, impotence, or frigidity (cf. 2.4; 2.4.3; 2.4.5).

The vast majority of people with an anxiety disorder can be helped with the right professional care. The treatments that work best for depression also combat anxiety. It is possible to prevent many dreaded diseases by focusing on emotional health (cf. 2.4.6).

Mood disorders are often linked to suicide. The suicide rate studies indicate that suicide has been on a shocking increase in recent years. This escalating death rate has occurred in spite of the billions of antidepressant drugs and tranquilisers that have been dispensed during the past several decades. Self-destructive behaviour and suicide/suicidal intentions are synonyms and a combination of factors may lead to it (cf. 2.6; 2.7)

Based on semi-structured interviews with the experimental group it can be concluded that faith has played a significant role in the counselees' recovery from or ability to cope with their mood and anxiety disorders (cf. 2.8.4).

Depression and anxiety are complex conditions to handle or cope with. This chapter offered an overview of the viewpoints and research conclusions from the major scientific disciplines involved in mental health regarding depression and anxiety. This knowledge is essential for developing an integrative model (chapter 5) for dealing with depression. During the last century, practitioners of different clinical disciplines – psychiatry, psychology and social work – have claimed jurisdiction over matters of the mind. However, increasingly these disciplines are conceding that while they have much to offer, perhaps they do not offer all the answers (cf. 2.2). The importance of the relationship between spirituality and health is also continuing to spread amongst leading medical educators; realising that medical treatment alone does not always result in healing of mood and anxiety disorders.

Chapter three will explore the scriptural perspectives related to *mood and anxiety disorders* and faith. The basis-theories (chapters 3 and 4) and biblically sound meta-theory (chapter 2) will be used in hermeneutical

CHAPTER THREE

BASIS-THEORETICAL PERSPECTIVES ON THE HEALING POWER OF FAITH IN MOOD AND ANXIETY DISORDERS: AN EXPOSITORY APPROACH

3.1 OBJECTIVES

The objectives of this chapter include studying scriptural perspectives related to mood and anxiety disorders (and focusing on what popularly is called "depression") and faith, and to research the revelation historical stance on this. Furthermore, this chapter will investigate the answers offered to depression sufferers in holding on to faith by studying scriptural examples pertaining to what today is called *depression*: Lamentations and the accounts of the harmful role that depression played in the lives of key Old Testament figures (Moses, Job, Elijah, David and Jeremiah). A brief overview will be given of the way in which healing, faith and depression are understood in the Old and New Testament. Finally some perspectives will be summarised.

The method of Zerfass (Zerfass, 1974:166; cf. Heitink, 1999:113; Heyns & Pieterse, 1998:34-37), in terms of identifying basis, meta, and practice theories will be employed. The basis-theory involves the biblical perspectives regarding mood and anxiety disorders as these transpire through expositional studies of various biblical passages and the hermeneutical fundamentals involved in this. This is attempted in this chapter by expositions of certain Bible passages which provide biblical guidelines for dealing with mood and anxiety disorders. Expositional studies of the following Bible passages will also be done, as it may offer answers to depression sufferers: 2 Corinthians 1:3-11, Philippians 4:4-13 and Lamentations.

Since there are so many *popular theological/biblical* approaches to the problem, it will be discussed in the next chapter.

3.2 INTRODUCTION

Affect is the medical term for *emotional state* or *mood*; **affective disorders** are disorders of *mood* (cf. Anderson & Anderson, 2004:18). Allender and Longman (1995:135) view depression as a continual state of *mind* and observe that the defining trait of depression is something *life-absorbing*. Anderson and Anderson (2004:16) describe depression as an ache in the soul that crushes the spirit. Some people see depression as the *designer disorder* of this age, implying that this disorder somehow became more prevalent with the introduction of effective medications to treat it (Biebel & Koenig, 2004:15). However, according to Biebel and Koenig (2004:15; cf. 2.2) depression is as old as humanity, at least since Adam and Eve were driven from their place of perfect peace. When Adam and Eve fell in the garden, their emotions fell too. Ever since that day, mankind's emotions have been fickle, misleading, and often simply wrong (Coe, 2004:40). Allender and Longman (1995:34) suggest that all dark emotions are rooted in one's *reactive* response (flight) to being out of the Garden and people's *aggressive* response (fight) to regain access to Eden. Because of this, one cannot base one's actions and decisions solely upon one's feelings.

It does not make any difference whether the precipitating cause of depression is physical, mental or spiritual (Anderson & Anderson, 2004:10): depression and anxiety affects the *whole* person, and a complete cure requires a *holistic* answer (cf. Anderson & Miller, 1999:19; 2.3.1). No human problem manifesting in one dimension of reality can be isolated from the rest of reality (cf. Coetzer, 2006:7). Like any other sickness of the body and soul, depression is a whole-life problem that requires a whole-life answer. David was said to have a whole heart for God; yet his numerous bouts of depression are recorded throughout the Psalms (see 3.3.4). Anderson and Anderson (2004:10) go on to say that depression is related

to a person's *physical health*, what they *believe*, how they *perceive* themselves, their *relationship with God*, their *relationship with others*, the *circumstances* of life, and finally, it may have something to do with *Satan*, who is the god of this world. One cannot successfully treat depression without taking into account all related factors. According to Anderson and Miller (1999:19), most of the time anxiety is overcome by *faith* in God, and *spiritual attacks* are overcome by worshipping God in one's daily life. Louw (2000:176) points out that people need to integrate God into their suffering through *faith*. This requires an image of God that does not view Him as immutable, but as a compassionate Friend and Companion for Life, who, through the covenant dialogue and as a result of Christ's high-priestly work, is able to identify with one's weakness and vulnerability.

According to Campbell-Lane and Lotter (2005:118), Christian *spirituality* describes the life of grace of living in fellowship with God. Whitney (1991:131) indicates that godliness is the result of a disciplined spiritual life. Spirituality is not just the "spiritual part" of man, but includes the life of the *whole person* (Campbell-Lane & Lotter, 2005:118). There are essentials in *spirituality* which are the same for all Christians, both in the aim (being conformed to the likeness of Jesus Christ – Romans 8:29) and in the means (the spiritual disciplines). Spirituality is not a mere technique to be mastered, but is a response of total dependence of the creature on his Creator – God Almighty (Campbell-Lane & Lotter, 2005:118).

Ryken (1999:37) argues that although the details are different for every person, a *spiritual change* generally happens through God sending his Spirit into a person's heart. The Holy Spirit convinces that person that he/she is a sinner in need of God's forgiveness (cf. Joubert, 2005:253). This is called *repentance*. Next God's Spirit helps that person to believe that Jesus Christ died for their sins. This is called *faith*, and it leads to eternal life. When one repents of one's sins and puts one's *faith* in Jesus Christ, one becomes a whole new person (cf. Reymond, 1998:736).

The Heidelberg Catechism (question 21) addresses the question "what is *true faith*?" as follows:

> *True faith is not only a certain knowledge, whereby I hold for truth all that God has revealed to us in his word, but also an assured confidence, which the Holy Ghost works by the gospel in my heart; that not only to others, but to me also, remission of sin, everlasting righteousness and salvation, are freely given by God, merely of grace, only for the sake of Christ's merits.*

Vought (2000:256) stresses that *healing* is a process that takes time, but when one sees the fruit of the Spirit in a person's life – living in the light and in truth – one knows he or she has found freedom (cf. Mitchell, 2004:117). According to Louw (1994:118), faith is actually a source of comfort and consolation, provided that it is active and alive.

In conclusion, anxiety disorders are the most common emotional struggles of today. Depression and anxiety affects the *whole* person, and a complete cure requires a *holistic* answer – physically, mentally, emotionally, socially, environmentally, and above all *spiritually*. Faith is therefore important in dealing with depression. Hope, faith and love (cf. 1 Corinthians 13:13), are valuable, sacred commodities in the lives of those who struggle to preserve *mental health*. The remainder of this chapter will therefore focus on these issues. Scriptural perspectives on depression, faith and healing will be discussed in 3.3; and the answers offered to depression sufferers in 2 Corinthians 1:3-11 and Philippians 4:4-13 will be analysed in 3.4.

3.3 SCRIPTURAL PERSPECTIVES ON DEPRESSION, FAITH AND HEALING

This section will focus on proposed scriptural perspectives on mood and anxiety disorders (3.3.1), faith (3.3.2) and healing (3.3.3) and on the harmful role of depression in the lives of key Old Testament figurers (3.3.4).

3.3.1 Proposed scriptural perspectives on mood and anxiety disorders

The Bible does not use the words *mood* and *anxiety disorder* or *depression*, although it describes people who might be suffering from it. According to SCB (2001:780), Job experienced financial, personal and relational losses that led him to curse the day he was born (Job 1-3). While struggling with his suffering, Job "cursed the day of his birth" (Job 3:1), saying "I will speak in the anguish of my spirit, I will complain in the bitterness of my soul." (Job 7:11). He also cried, "My spirit is broken, my days are extinguished, the grave is ready for me." (Job 17:1; cf. 3.3.4).

Copeland (2004; cf. Seamands & Funk, 1992:151; Burkett, 1998:122) remarks that great men of God have been known to suffer "depression": men like Elijah, who was so depressed after a great victory that he wanted to die (1 Kings 19:4; cf. 3.3.4), David, and also Jeremiah who declared "Why did I ever come forth from the womb to look on trouble and sorrow?" (Jeremiah 20:18). After Jonah witnessed the astounding grace of God among the wicked Ninevites, he angrily said, "Death is better to me than life" (Jonah 4:3; cf. Solomon, 1998). David wrote about his depression caused by unconfessed sin, leading to a groaning in his soul and a loss of strength (Psalm 38). According to SCB (2001:780), God used depression as a signal to get Nehemiah's attention to do His work (Nehemiah 1; 2). Many other Bible characters also shared the lonely path of depression (SCB 2001:780).

According to Floyd (2002), anxiety may be the antithesis of faith: when a person is anxious, he does not believe and when he believes, he is not anxious. Foster (1998:87) concludes that freedom from anxiety in a negative sense is one of the inward evidences of seeking first the kingdom of God (cf. Matthew 6:25-33). Freedom from anxiety, according to Foster (1998:88), is characterised by three inner attitudes. One will possess freedom from anxiety if one believes that what one owns:

- has been received as a gift;
- is to be cared for by God; and
- is available to others.

However, if one believes that one has earned what one owns, and if one believes that one must hold onto it and does not make it available to others, then one will live in anxiety (Foster, 1998:88). Foster (1998:89) explains that when one is seeking first the kingdom of God, these three attitudes will characterise one's life. Together they define what Jesus Christ means by "do not be anxious". The above-mentioned attitudes comprise the inner reality of Christian simplicity.

Both psychology and the Scriptures point to the fact that anxiety can be either normal or abnormal. Considering the fact that God created man and gave people emotions, it can be concluded that sin is the cause of unhealthy or out of control emotions. God initiated this by sending His Son (John 3:16). The good news is that *Saving faith* produces salvation from the penalty of sin and *Living faith* is required not only for preservation from the *penalty* of sin but also for the deliverance from the *power* of sin (see 3.3.2). The effect of sin must be dealt with in order for *healing* to occur. The presence of something similar (or alike) mood and anxiety disorders in the Bible will be discussed more fully in 3.3.4.

3.3.2 Proposed scriptural perspectives on faith

The word that is commonly translated as *faith* in the Bible means more than mere *belief* (Fitzpatrick, 2002:181). It also implies dependence and trust. Faith, because it incorporates dependence and trust, also embodies *action*. This action can take many forms, but belief that does not eventuate in a changed life is not true biblical faith. According to Fitzpatrick (2002:181) faith is *living ... it moves ... it can be perceived*, because true faith trusts and depends on God. Fitzpatrick (2002:182) observes that the one chapter in the Bible that is entirely devoted to people of faith; is Hebrews 11. The King James version defines *faith* in Hebrews 11:1 as "the *substance* of things hoped for, the *evidence* of things not seen". The *New American Standard Bible* says in the same verse, "Now faith is the *assurance* of things hoped for, the *conviction* of things not seen". Craddock (1998:131) indicates that in this brief introductory of Hebrews 11, the writer makes the affirmation that informs and focus the recital that follows: the *nature of faith*. He points out that one can argue that verse 1 does not "define" faith. Rather than offering a definition, the author focuses and gives thematic unity to the discussion and gives living examples from the revelation history (Craddock, 1998:131).

In Hebrews 10:36-39, faith is presented in a context of related words: *assurance*, *endurance*, and *firm hope in the promises from which we do not shrink back*. Craddock (1998:131) illustrates that the orientation is eschatological, and that perspective will prevail through Hebrews 11:1 – as used here, faith cannot be separated from hope. The language of faith (*believe*, *trust*, *faithful*, *reliable*, etc.) is essential to human relationships in general, but gains its special biblical connotations from the interaction of God with humanity, his reliability and our response of trust in him (France, 1992:223). De Bruyn (1997:168; cf. Smith, 2005:60; Wallis, 1995:16) stresses that faith comes from God; and more specifically from God the Holy Spirit; not from people. Man stands powerless towards the gift of faith; he cannot *bring forth* faith by himself. It is the Holy Spirit

who works faith in people (*Van Bruggen, 2000:169*). Reymond (1998:731) indicates that as is the case with repentance unto life, faith in Jesus Christ is represented in Scripture as a "saving grace", that is, as a gift.

According to Smith (2005:61), faith sees God as He is. Faith believes what God can do. Faith anticipates what God will do. Faith believes God has the power. Benson (2003:29) shows that faith is *belief based on facts* (cf. 3.2). The Gospel is a statement of definite, historical facts that the Old Testament saints were confident *would* occur and that the New Testament saints believed *had* occurred. "I declare unto you the gospel which I preached unto you," said Paul; and then he made plain exactly what the Gospel is: "that Christ died for our sins according to the scriptures; and that he was buried, and that he rose again the third day according to the scriptures." (1 Corinthians 15:1-4). Benson (2003:29) explains that these are three remarkable facts: the substitutionary death of Christ, His burial, and His *resurrection*.

However, faith is more than recognition of facts. A person may know all about Christ as revealed in the Bible, may even believe God's Word to be true, and yet not have real faith in Christ as his personal saviour (Benson, 2003:29). Agreement by the mind is not the same as surrender of the heart. Satan and the fallen angels believe in God to the extent that they tremble for fear of Him (James 2:19). Benson (2003:30) also points out that faith not only *accepts* but also *believes* and *applies* the facts. Faith involves the *affections* and the will as well as the intellect. Faith harmonises the will and the understanding. Anderson and Anderson (2004:56) explain that God never bypasses the mind. He works through it, and people are transformed by the renewing of their minds (to follow in 3.4.2). He makes possible the renewing of people's minds by His very presence in their lives.

Spykman (1992:24) reports that at the First Vatican Council, convened in 1869-1870, the declaration was made that reason and faith cannot be contradictory:

> *But although faith is above reason, there can never be any real discrepancy between faith and reason, since the same God who reveals mysteries and infuses faith has bestowed the light of reason on the human mind, and God cannot deny himself, nor can truth ever contradict truth. The false appearance of such a contradiction is mainly due, either to the dogmas of faith not having been understood and expounded according to the mind of the Church, or to the inventions of opinion having been taken for the verdicts of reason.*

Faith is "the conviction of things not seen." According to Benson (2003:30), faith enables the seeking soul to penetrate into the spiritual realm. Faith is the source of all spiritual achievement. For Fitzpatrick (2002:185) *faith is: the knowledge of God's character, the belief that He's able to do all that He's promised, and the trust to follow Him wherever He leads.* "By it the men of old gained approval" (Hebrews 11:2): Craddock (1998:131) writes that this is the approval of God on the life that was determined by such faith as described in Hebrews 11:1. Abel, Enoch, Noah, Abraham, Isaac, Jacob, and many others have their names inscribed in the Bible's "hall of fame", not because of their wealth or wisdom or worldly achievements, but because of their faith (cf. Fitzpatrick, 2002:182). "Without faith it is impossible to please Him: for he that cometh to God must believe that he is, and that he is a rewarder of them that diligently seek him." (Hebrews 11:6). It was the affirmation that "Enoch pleased God" that not only earned him a place on the list of heroes of faith but also provided the author of Hebrews an exegetical base for the general principle regarding faith (Craddock, 1998:133). Craddock (1998:133) observes that the argument unfolds in this way: If Enoch pleased God, then Enoch was a person of *faith*, because "without faith it is impossible to please God" (v6).

According to Foster (1998:39), people sometimes are afraid that they do not have enough faith to pray for this child, or that marriage for instance. But their fears should be put to rest, for the Bible says that great miracles are possible through

faith the size of a mustard seed (Matthew 17:20). Foster (1998:39) reminds us that usually the courage actually to go and pray for a person is a sign of sufficient faith. Frequently one's lack is not faith but compassion. In Hebrews 11 people were described whose faith had been transformed *from weakness to strength* (Fitzpatrick, 2002:186). According to Benson (2003:30), there are three types of *faith* – saving, living, and working:

- *Saving Faith*

  Benson (2003:30; cf. Reymond, 1998:449) describes how Adam's sin brought death to the human race. "Dust thou art, and unto dust shalt thou return," (Genesis 3:19) was the divine decree issued to the first parents. The all-important question that every person must ask is, "If a man dies, shall he live again?" (Job 14:14). People may want one thing today and another tomorrow, but at the time of death the one thing they want above everything else is life, which can be had only through Christ; "I am come that they might have life" (John 10:10).

  Saving faith produces salvation from the penalty of sin (John 3:16-18); it is *belief* in the only Saviour appointed for this purpose (Benson, 2003:30). According to France (1992:225) such "believing" is closely related to "knowing". If to believe is the key to eternal life (3:16, etc.), so also is "to know" (17:3). Without faith in Christ, a person will be deprived of heaven's happiness through eternity (John 3:36). He or she must share forever the punishment that has been prepared for the devil and his angels (Matthew 25:41). Those with *saving faith* believe with the heart (Acts 16:31) and confess with the mouth (Matthew 10:32). According to Benson (2003:30) with the heart there is recognition that the Lord Jesus is the sinner's substitute, and with the mouth there is confession not only of a hopeless condition, but of the Lord Jesus Christ as personal Saviour (Romans 10:8-11).

Reymond (1998:726) argues that according to Scripture, "saving faith" is comprised of three constituent elements: knowledge (*notitia*), assent (*assensus*), and trust (*fiducia*).

- Knowledge (*notitia*) is the cognitive foundation or base of saving faith.
- Assent (*assensus*) refers to the intellectual or cognitive conviction that the knowledge one has acquired about Christ is indeed factually true and that the provisions of the gospel of Christ correspond exactly to one's actual (not necessarily "felt") spiritual needs.
- As assent is cognition passed into conviction, so *fiducia* (trust) is conviction passed into confidence. Reymond (1998:728) shows that it is particularly this third element of *trust* or confidence that is saving faith's most characteristic act, as the sinner cognitively, affectively, and volitionally transfers all reliance for pardon, righteousness, and cleansing away from himself and his own resources in complete and total abandonment to Christ, whom he joyfully receives and upon whom alone he rests entirely for his salvation.

Upon Calvary's three crosses hung three representatives of the human race (Luke 23:39-43). The two malefactors were alike in their sin; they were alike in their condemnation (Benson, 2003:31). However, in their last moments, one cruelly mocked the Lord and called Him an impostor, unable to save Himself and these guilty thieves, while the other rebuked his companion's blasphemy and then cried to Jesus Christ for salvation. Benson (2003:31) indicates that he recognised the justice and judgment of God, admitted his own guilt, confessed the Saviour, and asked for salvation. Here was a man who in his dying breath had *faith* enough to recognise Jesus Christ as King. Therefore the Lord said to him, "Today shalt thou be with me in paradise." (Luke 23:43).

- *Living Faith*

According to Benson (2003:31), faith is required not only for preservation from the *penalty* of sin but also for the deliverance from the *power* of sin. Spykman (1992:312) explains that man is sinful (Romans 3:23), and all pain in this world is caused by it in the life of the believer. The effect of sin must be dealt with in order for *healing* to occur. Once people understand the love of God as expressed in Jesus Christ, they are not to continue in sin. According to Campbell-Lane and Lotter (2005:115), the Christian must present himself as an instrument of obedience to God and not to sin. It is essential to realise that although sin remains, it does not have mastery over the believer. How then is one to persevere when one is tempted?

Van Bruggen (2000:170) has found that faith needs strengthening, because it constantly faces attacks by one's sinful nature and the entire evil world (cf. Collins, 1993:239), which contradict it. The Lord strengthens faith in different ways (for example through testing and his guidance of one's entire life). God uses temptation to test *faith* (Benson, 2003:31; cf. Van Bruggen, 2000:170). This does not mean that God tempts people, for God is not the author of evil (James 1:13), but He allows Satan to do so: God *tests*, but Satan *tempts*. Moreover, Satan's temptations can be recognised, for they are common to all people; and they can be resisted, for a way of escape has been promised (1 Corinthians 10:13). Believers must rejoice in the midst of temptation since it is proof of God's loving discipline (James 1:2-3).

The only one who can deliver us from temptation is the Lord Jesus Christ (Hebrews 12:2). He was tempted in all points as people are and yet was without sin (Hebrews 4:15). Faith in His victory and His power is the shield with which we are "able to quench all the fiery darts of the wicked (one)" (Ephesians 6:16).

- *Working Faith*

  Benson (2003:32) points out that sinners are saved by faith (cf. Ephesians 2:8; Anderson & Anderson, 2004:56), not by works; but it is by works that they demonstrate and prove their faith (cf. Van Bruggen, 2000:161). Christians are God's "workmanship, created in Christ Jesus unto good works, which God hath ordained that we should walk in them" (Ephesians 2:10). Though not created in Christ Jesus *by* good works, believers are created *unto* or *for* good works (Titus 2:14). Works do not justify people, but justified people work. Work is the fruit of *faith* (cf. Van Bruggen, 2000:161). An inactive Christian life is empty and unfruitful. Work is not the *foundation* but the *completion* of faith (Benson, 2003:32). James is called the apostle of works, but he does not maximise the importance of faith (2:14-26). James had insisted in 1:22-25 that his readers be not only hearers of the word but also doers (Johnson, 1998:106; cf. Collins, 1993:208). Now he insists that "faith alone" is not adequate without the *deeds* of faith (2:18-26). True *faith* will express itself in actions. James teaches that where there are no good works and no true religion (cf. James 1:27), and a faith that is not producing good works is of *no* value. In 2:14-16 James shows how false a faith is that refuses help to those in need (Johnson, 1998:106). Benson (2003:32) indicates that actions must be regarded as the evidence of a justified person.

From the above it can be concluded that *faith* is not only essential for salvation but is also the anchor for the soul. Instead of allowing one's fear to take over when life feels "out of control", one is asked to take a step of faith and "cast all your anxieties on the Lord because He cares for you" (1 Peter 5:7).

In paragraph 3.3.3 the connection between faith and healing is further explored.

3.3.3 Proposed scriptural perspectives on healing

The Bible is full of accounts of **healing**; particularly the Gospels (cf. Reymond, 1998:553). Jesus, Paul, and the rest of the early church lived in regular expectation that God would heal people's physical bodies (Fee, 1999:168; Wallis, 1995:56). This expectation was based in part on the Old Testament promises that in the messianic age God would "heal" his people. Matthew 8:17 uses Isaiah 53:4 to refer to Jesus' ministry of healing the sick. The Isaiah passage itself is ambiguous; it is clearly a metaphor for salvation, but in prophetic tradition such salvation also included the healing of people's wounds incurred in their judgement. Thus, in the New Testament Isaiah 53:4 is understood both as a metaphor for salvation (1 Peter 2:24) and as a promise for physical healing (Matthew 8:17). According to Acts, such healings accompanied Paul's own ministry; they are probably also referred to by Paul himself in "the signs of an apostle" in 2 Corinthians 12:12 (cf. Romans 15:19).

In a "scientific age" it is common to reject the possibility of God's healing of the sick (Fee, 1999:168). Unfortunately, this is also true of many contemporary Christians, whose theology has made a severe disjunction between the "then" and the "now" of God's working. This seems to be a seriously flawed understanding of the kingdom, which continues the work of the kingdom until the consummation. Indeed, this seems to be a thoroughgoing denial of the New Testament view of the Spirit. Compassion was an evident feature of every healing in the New Testament (Foster, 1998:40; cf., Faw, 2004:38). Jesus was "moved with compassion" for people, and He still is today.

According to all four canonical Gospels, Jesus Christ devoted a considerable part of his ministry to performing **miracles of healing** for a wide variety of people (cf. Tomson, 2001:30). Stanton (2001:64) shows that there are seventeen accounts of healing in the gospels. According to Blomberg (1992:299; cf. Wallis, 1995:59) these miracles sometimes occurred in response to *faith* and sometimes to instil

faith. Blomberg (1992:300) continues that Jesus Christ regularly helped blind people to see (Matthew 9:27-31; Mark 8:22-26), the deaf to hear (Matthew 11:5; Mark 7:32-37) and the lame to walk (John 5:1-15). He cleansed lepers (Luke 5:12-16; 17:11-19), cured fevers (Mark 1:29-31; John 4:43-53), stopped a haemorrhage (Mark 5:24-34), restored a withered hand (Mark 3:1-6), replaced a cut-off ear (Luke 22:51) and healed a wide variety of unspecified illnesses.

In the Bible, Jesus Christ often said to those who came to Him: "Your faith has healed you." (example Luke 8:48). He required people to have faith. Van der Walt (2006:197) concludes: first faith, then the miracle – it is never the other way round. When Jesus was here on earth, He asked two blind men: " 'Do you believe that I am able to do this [have mercy on you and heal you]?' 'Yes Lord,' they replied. Then He touched their eyes and said, 'According to your faith will it be done to you.' " (Matthew 9:28-29). Jesus also wanted to be satisfied that their faith was real (Smith, 2005:62). With two words ("Yes Lord") they affirmed Christ's identity (earlier they had addressed Him as "Son of David") and confessed their faith in Him. According to Smith (2005:62), this dual admission released God's power for their healing. Their faith in God was genuine. Anderson *et al.* (2000:104) argue that the external power of Jesus Christ was made effective by the men's choice to believe. In other words, the Lord chose to bring about a physical healing through the channel of their faith (Anderson *et al.* 2000:104; cf. Anderson & Anderson, 2004:56; Blomberg, 1992:300).

Depression is not necessarily a sign of spiritual failure (Seamands & Funk, 1992:153). In the Scripture stories, some of the greatest depressions came as emotional letdowns following the greatest spiritual successes. This was true in the life of Elijah (which will be discussed in 3.3.4). After that greatest moment in his life, the triumph over the prophets of Baal on Mt. Carmel, he is pictured sitting alone under a juniper tree, asking God to take his life. Abraham had a similar experience (Genesis 15), and many Christians have too. Depression seems to be nature's emotional kickback. It is a reaction like the wallop from firing a gun of

heavy caliber. It is nature's recoil, or perhaps the balance wheel in what C.S. Lewis calls "the law of undulation" in the human personality (Seamands & Funk, 1992:153).

Foster (1998:195) maintains that the decision to set the mind on the higher things of life is an act of the will. It is the result of a consciously chosen way of thinking and living. When one chooses this way, the healing and redemption in Christ will break into the inner recesses of one's life and relationships, and the inevitable result will be joy (cf. Philippians 4:4). Coetzer (2006:9) stresses that God's healing encompasses the whole person and affects a person in his/her totality.

Van der Walt (2006:198) indicates that **Jesus Christ only performs His miracles where there is faith**:

- He *tests if there is faith* (for example, the Canaanite woman: Matthew 15:22; Mark 7:24-30; the man born blind: John 9:6-7). Fleming (1994:425) shows that when the woman asked Jesus to drive the demon out of her daughter, he tested the genuineness of her faith before helping her. At first he did not answer, but the woman persisted (Matthew 15:22-23). Fleming (1994:425) continues that Jesus was impressed with the genuineness of the woman's faith and granted her request immediately (Matthew 15:26-28).
- According to Van der Walt (2006:199), He immediately *notices faith* (the paralytic of Capernaum: Mark 2:5). Fleming (1994:413) writes that Jesus did more than heal the man. He went to the root of all suffering in a fallen world, sin, and on the basis of the faith that had been displayed, he announced forgiveness of the man's sins.
- Van der Walt (2006:199) points out that He *calls people to faith* (Jairus: Mark 5:34, 36) and He *acclaims faith* (the sick woman: Mark 5:34). A sick woman believed that if she could only touch Jesus' clothing she would be healed (Mark 5:25-29). Jesus knew that someone was seeking His help in

this way, and did not want the person to be left with any superstitious ideas. He therefore searched for the woman so that she might show her faith openly and be healed completely (Mark 5:30-34). Fleming (1994:422) explains that Jairus' faith was tested when he heard that while Jesus was healing the woman, his daughter (where Jesus was on His way to) had died. Jesus responded by working a greater miracle than what Jairus had expected, for He brought the girl back to life (Mark 5:35-42).

However, Jesus Christ never uses or abuses His miraculous power to overwhelm people and to coerce or force them into faith (Van der Walt, 2006:198). This is what the devil wanted Jesus Christ to do in the second temptation (Matthew 4:5-7; Luke 4:9-11). Van der Walt (2006:200) also shows that Christ never makes a show of His miracles. He bluntly refuses any kind of demonstration whatsoever (for example, Matthew 16:1-4; Mark 8:10-11). One needs to recognise that Jesus Christ is able to heal. However, if one is faithful, and has prayed, one has to trust God that He knows what He is doing, if He leaves one unhealed. Louw (1994:106) indicates that healing is a *gift* and not necessarily a *right*. Deeper than asking for healing, then, lies the dependence on and trust in God.

There is a fundamental **difference between *faith* healing and *divine* healing**, in that faith is an important component for healing, but it is always *faith in God* (Smith, 2005:61). One need not seek a heightened state of consciousness. Nor does one work up some intense emotion. Nor does one need an elevated state of mind. These are all expressions of what true faith is not. Faith in itself has no inherent power to cure anybody. Nor will placing one's hope in some dynamic faith healer make the difference. Smith (2005:61) explains that *the real source of power in divine healing is the Lord of heaven and earth, the God of the Bible, the personal God who fully revealed Himself in Jesus Christ.* It is this God in whom one is putting one's trust! When one has faith in faith, the direction of one's gaze is *inward*. When one has faith in God, the direction is *upward*. According to Smith

(2005:61), *healing* may come when one's vision of God is finally greater than one's own need.

Campbell-Lane and Lotter (2005:99) observe that **inner change** is not only the ultimate objective of counselling, but is also a basic tenet of the gospel. According to Crabb and Allender (1996:103), healing the *soul* requires the *disruption* of one's *most* deeply embedded lies and illusions. Healing does not occur as long as people are free to manipulate life to gain what only God can provide. God listens to prayer and is able to answer. He is also able to intervene and *heal* if He deems it fit.

Modern medical research is proving **the positive relationship between health and godliness**, a fact that believers have understood for a long time (SCB, 2001:803). Religious commitment was shown to counteract the hopelessness and despair of depression (SCB, 2001:402). Seventeen different studies over four decades showed that less distress, a greater sense of well-being, and the occurrence of fewer psychiatric symptoms were all related to higher levels of religious commitment and church participation (SCB, 2001:403). Regular prayer and biblical meditation leads to increased peace and tranquillity, a very effective passive approach for reducing worry and generalised anxiety (cf. Anderson & Miller, 1999:227). Foster (1998:17) has found that Christian meditation, very simply, is the ability to hear God's voice and obey his word – it involves no hidden mysteries, no secret mantras, no mental gymnastics, no esoteric flights into the cosmic consciousness.

Foster (1998:15) also indicates that *repentance* and *obedience* are essential features in any biblical understanding of meditation. The psalmist exclaims in Psalm (119:97, 101, 102):

Oh, how I love thy law! It is my meditation all the day...I hold my feet from every evil way, in order to keep thy word. I do not turn aside from thy ordinances, for thou hast taught me.

Foster (1998:16) writes that it is this continual focus upon obedience and faithfulness that most clearly distinguishes Christian meditation from its eastern and secular counterparts.

According to Louw (1994:65), **healing in medicine is not segregated from the salvation in Christ**. Medicine is a sign which points indirectly towards the salvation in Christ and God's sovereignty over all creation. From the perspective of *faith*, medical care and therapy are metaphors for creation on its way to the eschatological event of the new creation. Louw, 1994:65 (cf. also Hart & Weber, 2005:179) further argues that true *healing* and recovery, viewed from a *faith* perspective, must, in terms of Scripture, be seen as follows: *reconciliation* and *peace* with God.

Living a godly lifestyle brings physical, emotional, and spiritual health and blessing (SCB, 2001:803; Reymond, 1998:976). Being a believer will not exempt a person from physical problems, but at times it may keep a person from some kinds of diseases or accelerate the healing process. And knowing that one belongs to God brings spiritual contentment that will have a positive effect on the body as well.

The real source of power in divine healing is the Lord of heaven and earth, the God of the Bible, the personal God who fully revealed Himself in Jesus Christ (Smith, 2005:61). True believers live out their faith and walk daily in the presence of God (cf. 3.3.4). They live longer and stay healthy longer, show high levels of life satisfaction, higher levels of personal contentment, have an ability to endure hardship and suffering, and show a consistently higher practice of forgiving others (SCB, 2001:403).

In conclusion, there is no doubt for the Christian that God can heal if He deems fit. God wants people healed, living among healthy people, and enjoying peace (cf. John 10:10).

3.3.4 The harmful role that "depression" played in the lives of key Old Testament figures: Moses, Job, Elijah, David and Jeremiah

Many people think there are no records in the Bible of anyone being depressed (Morton, s.a.) The thought is: "if God is speaking directly to someone (like the prophets of the Old and New Testament), how could they be depressed?" However, many instances are recorded where certain individuals struggled when facing problems. The Bible tells of kings and prophets who became depressed (Meyer, 1998:5). King David, Moses, Job, Elijah and Jeremiah are good examples.

a. Moses

The first person used as an example of how people in the Bible suffered from depression, is Moses. It is hard to understand, as Moses was the chosen one through whom God would deliver the nation of Israel from captivity in Egypt. He also was God's chosen person through whom the law (Mosaic Covenant) was given to the nation of Israel. Moses had a close relationship with the Lord and spoke with Him many times (Morton, s.a.; cf. Foster, 1998:17). It is, therefore, hard to see that Moses could have been depressed.

According to Fowler (1999), scriptural examples of Moses' depression, discouragement and dejection includes Numbers 11:10-15: *afflicted* and *burden* (verse 11); *burdensome* (verse 14); *suicidal* (verse 15).

Moses experienced unrelieved stress trying to keep two million Israelites happy as they wandered in the wilderness. Moses discovered a mentor when he

needed one most (SCB, 2001:103). He received it from Jethro, his father-in-law (Exodus 18:17-18). Jethro saw his son-in-law burning the candle at both ends. He saw the dysfunctional judging process that Moses attempted to shoulder alone (cf. Murphy, 1979:196), and he suggested a better way. He encouraged Moses to delegate the judging of some of the minor disputes to godly men who were able to know the people and deal intimately with their needs (cf. Fleming, 1994:37). Murphy (1979:196) remarks that a division of the labour was necessary, that it could be done promptly and efficiently. Jethro demonstrated that those outside a situation can often bring valuable perspectives to those who may be overwhelmed in it and to involve other people in helping one with one's tasks at hand.

This account in Scripture is one example where one sees *negative thinking* associated with someone who is depressed (Morton, s.a.). Moses was dealing with the members of the nation of Israel in the wilderness (Numbers 11). They were complaining about their circumstances and were saying they were better off while in captivity in Egypt. Morton (s.a.) states that Moses was very displeased by what had occurred and that he started to have some serious doubts about what he had been called to do. Moses complained to God that the responsibility of looking after the complaining multitude was a burden greater that he could bear (Fleming, 1994:69). He started talking about himself in a very disparaging way as though he did not have favour in the sight of God (Morton, s.a.). This often happens to people who are dealing with depression (Morton, s.a.)

Moses seemed drawn to what needed to be righted (LASB, 2005:117). Throughout his life, he was at his finest and his worst responding to the conflicts around him. Even the burning bush experience was an illustration of his character. Having spotted the fire and seen that the bush did not burn, he had to investigate (Exodus 3:3). Whether jumping into a fight to defend a Hebrew slave or trying to referee a struggle between two kinsmen (Exodus 2:12), when Moses saw conflict, he reacted.

Leadership often involves reaction (LASB, 2005:117). If one wants to react with instincts consistent with God's will, one must develop habits of obedience to God. Consistent obedience to God is best developed in times of less stress. Then when stress comes, one's natural reaction will be to obey God. According to LASB (2005:117), over the years, an amazing thing happened to Moses' character. He did not stop reacting, but rather learned to react correctly. The kaleidoscopic action of each day of leading two million people in the desert was more than enough challenge for Moses' reacting ability. Much of the time he served as a buffer between God and the people. At one moment he had to respond to God's anger at the people's stubbornness and forgetfulness (LASB, 2005:117). At another moment he had to react to the people's bickering and complaining. At still another moment he had to react to their unjustified attacks on his character.

Fleming (1994:69) describes how God did not rebuke Moses for his outburst. He understood Moses' troubles and helped him through them. Moses learned, albeit with many vacillations and detours, how to hear God's voice and obey his word (Foster, 1998:17). In the same way, God will be there for those suffering from depression and anxiety; they just have to *prayerfully* seek Him.

According to LASB (2005:117), in this age of lowering moral standards, one finds it almost impossible to believe that God would punish Moses for the one time he disobeyed outright. What one fails to see, however, is that God did not reject Moses; Moses simply disqualified himself to enter the promised land. Personal greatness does not make a person immune to error or its consequences.

In Moses one sees an outstanding personality shaped by God (LASB, 2005:117). But one must not misunderstand what God did. He did not change who or what Moses was; he did not give Moses new abilities and strengths. Instead, he took Moses' characteristics and moulded them until they were suited to his purpose.

The following summarises Moses' strengths, weaknesses, accomplishments and the lessons learned from his life (LASB, 2005:117):

Strengths and accomplishments:

- Egyptian education; desert training.
- Greatest Jewish leader, set the exodus in motion.
- Prophet and lawgiver; recorder of the Ten Commandments.
- Spoke to God like a friend.

Weaknesses and mistakes:

- Failed to enter the promised land because of disobedience to God.
- Did not always recognise and use the talents of others.

Lessons from his life:

- God prepares, then uses, His timetable is life-sized.
- God does his greatest work through frail people.

Significance for depression sufferers

- Jethro demonstrated that those outside a situation can often bring valuable perspectives to those who may be overwhelmed in it and that it is beneficial to involve other people in helping one with one's tasks at hand. This is also true for depression sufferers, who need the help and *support of others* in their lives.
- Moses did not stop reacting, but he rather learned to react correctly.
- Moses learned how to hear God's voice and obey his Word. In the same way, God will be there for those suffering from depression and anxiety; they just have to *prayerfully seek Him*.

b. Job

Job was one of God's favourite people (Ryken, 1999:102; Carlson, 2005). He was the wealthiest and most famous man in the Middle East at the time (Job 1:3). Job was rich in character, rich in cash and rich in children – he was well balanced (Gettys, 2005). According to Fleming (1994:174), a popular belief in ancient times was that prosperity and well-being were proofs of godliness, but poverty and suffering were proofs of ungodliness. They were signs that God was either rewarding or punishing a person, according to whether that person's life was good or bad. Many people today also think that suffering, including depression, is God's way of punishing them.

Gettys (2005) states that Job was also a man of prayer, as is described in Job 1:5:

> *So it was, when the days of feasting had run their course, that Job would send and sanctify them, and he would rise early in the morning and offer burnt offerings according to the number of them all. For Job said, "It may be that my sons have sinned and cursed God in their hearts." Thus was Job did regularly.*

Father Job prayed for his children on a regular basis. He was an intercessor mediating on a regular basis on behalf of each of his children (Gettys, 2005; cf. Fleming, 1994:174). Job was so godly (Fleming, 1994:174) that God himself used him as the prime example of a righteous man (Job 1:8, 2:3a; cf. Gettys, 2005). Ryken (1999:102) recounts that there was no one on earth like Job, but no one has ever suffered the way he suffered either. Job did not deserve his troubles (Gettys, 2005). In short, through no fault of his own, he lost his oxen, donkeys, sheep and camels; his servants were slain by enemies; all his sons and daughters were killed in a tornado (cf. Fleming, 1994:174; LASB, 2005:765); and then he was afflicted with painful sores from the bottom of his feet to the top of

his head. After this onslaught, Job tore his robe, shaved his head, sat down among the ashes, and scraped himself with a piece of broken pottery.

Job, the paragon of patience, says, "Sighing comes to me instead of food; my groans pour out like water. What I feared has come upon me; what I dreaded has happened to me. I have no peace, no quietness; I have no rest, but only turmoil." (Job 3:24-26). Job's suffering is therefore more than physical. Fleming (1994:175) indicates that the inner conflict is more tormenting. According to what he has always believed, his great suffering means that he must be a great sinner, but he knows that he is not. What he as always dreaded has apparently come true: he is cut off from God and he does not know why (Fleming, 1994:175). In the same way, depression sufferers often feel cut off from God – that God does not want anything to do with them.

Job wanted to die. He had lost everything and he was devastated. He had been a wonderful friend of God; yet all this tragedy came upon him. He cried out that he wished he had never been born. He was completely overwhelmed (Carlson, 2005; cf. Gettys, 2005). However, Job 1:20 says that after Job tore his robe and shaved his head, he fell to the ground in worship. Gettys (2005) interprets this as a display of just how remarkable a man Job really was. Fleming (1994:174) also points out that in spite of his overwhelming distress, Job's devotion to God did not alter. Job 1:21 says: "Naked I came from my mother's womb, and naked I will depart. The Lord gave and the Lord has taken away; may the name of the Lord be praised." According to Habel (1985:69), God does not give and take away in the manner many mortals may wish, expect, or understand (cf. Gettys; 2005). For Job experienced God and his paradoxical ways as an insider. God creates the space in His order for the freedom of humans and the freedom of God, for the integrity of mortals and integrity of God, for the angry complaints of those in agony and the challenge of God in whirlwind or whisper (Habel, 1985:69).

Ryken (1999:102) indicates that apart from his wife, the only thing Job had left in the world were a few friends. His friends came from a long distance and sat beside him dutifully (Carlson, 2005). Ryken (1999:102) recounts that at first they were very sympathetic to his plight and because they loved him, they wept aloud, tore their robes, and sprinkled dust on their heads (Job 2:12). However, eventually what they had to say was not very comforting (cf. Fleming, 1994:174): all three of the "friends" had a ready-made conclusion about the calamity that came upon Job (Carlson, 2005). According to Ryken (1999:102; cf. Fleming, 1994:178) they offered conventional wisdom rather than God's wisdom (Job 15:18). Carlson (2005) states that Job's three friends were reasoning from experience, tradition and even common sense in their arguments. All three were very sincere and very concerned about Job, but all three had wrong ideas about God. Carlson (2005) continues that the wonderful reality is that God is not as He has been misrepresented by Job's friends to be: arbitrary, unforgiving and severe. He is fair and forgiving and kind. He is a God who could really understand Job's complaints. Even after Job admitted that he said things beyond his understanding, God was very generous. He was far more sympathetic than Job's fellow humans.

Job did not tolerate the course of action demanded by his friends (Habel, 1985:63). Instead, he explored a bold alternative for resolving the conflict between himself and God. Repeatedly, Job turns from disputing with the friends to confront God with the truth and the option of litigation.

The doctrinally correct view in those days was that a man's suffering was the result of his own sin (Ryken, 1999:103; cf. Louw, 2000:169; Fleming, 1994:174). Louw (2000:169) states that suffering, as part of the broken reality, was associated with admonishment and punishment: if Job was suffering, then it was obvious that God was judging him for his sins. Job's trials were Job's own fault; they attributed Job's calamities to a flaw in his character (cf. Faw, 2004:149; Anderson & Anderson, 2004:141).

Although the world seems to run by a system of cause and effect, there are some effects for which one cannot find a clear cause, and some causes that do not lead to the expected effects (LASB, 2005:771). One would expect Job's wealth and family to give him a very happy life, and, for a while, they did. However, the loss and pain he experienced shocked people. LASB (2005:771) says of the first two chapters of his story that it is more than one can bear. Job's faithfulness seems incredible, but even Job had something to learn and in turn, one can learn from him. Job's friends believed that the law of cause and effect applied to all people's experiences. Their view of life boiled down to the theory that good things happen to good people, and bad things happen to bad people. Because of this, they felt their role was to help Job admit to whatever sin was causing his suffering (LASB, 2005:771). All he needed to do was repent for his sins, and then everything would be fine (Ryken, 1999:103).

LASB (2005:771) points out that Job actually looked at life almost the same way as his friends. What he could not understand was why he was suffering so much when he was sure he had done nothing to deserve such punishment. The last friend, Elihu, did offer another explanation for the pain by pointing out that God might be allowing it to purify Job, but this was only partly helpful. When God finally spoke, he did not offer Job an answer. Instead, he drove home the point that it is better to know God than to know the answer (LASB, 2005:771).

The counsel Job received from his friends was clear, doctrinal and practical, but it was wrong (Ryken, 1999:103). Although Job's friends knew a little theology, they did not know how to apply it to his case. Just about the last thing Job needed was someone to straighten out his theology. He already believed in the only wise God. He accepted wisdom as one of the divine attributes (Job 9:4a). According to Carlson (2005), that is why it is so important that God says Job was perfect. He was not sinning and offending God. He was God's friend. He trusted God. All of these dreadful things happened to a *saint*, not a sinner. And Job knew he had not done anything wrong, but he could not understand why the entire calamity

happened and why he could not talk with God and clear up everything (Carlson, 2005). This story of Job and his three criticising friends show that if one has the wrong concept of God, one will end up criticising people when one should offer *comfort* and *hope* and *truth* (Carlson, 2005). Job's friends would have been of much more help to him by being silent. Sometimes, like in this case, silence and listening is better than speaking.

Although some pains have been cured, one still lives in a world where many people suffer. Job was not expecting instant answers for the intense emotional and physical pain he endured. What broke Job's patience in the end, however, was not the suffering, but not knowing *why* he suffered. According to SCB (2001:638) Job was shattered, broken and diseased. Yet, through it all Job "did not sin with his lips" (Job 2:10). Job lost everything, and yet he still did not sin. One thing he did, was to express his depression (Carlson, 2005). Even though bitterness roused in his heart he maintained his trust in God and acknowledged God (Carlson, 2005; SCB, 2001:657; cf. Ryken, 1999:104). He demonstrated healthy responses to depression. Gettys (2005) adds that Job was now unemployed, sitting on a pile of ashes at the town dump looking at the ten newly dug graves of his children. His body was covered with oozing sores, his skin was diseased and his eyes sunken; yet he remained *faithful* to God. James 5:11 says: "We give great honour to those who endure under suffering. Job is an example of a man who endured patiently. From his experience we see how the Lord's plan finally ended in good, for he is full of tenderness and mercy."

Fowler (1999) lists the following scriptural examples of Job's depression, discouragement and dejection: Job 7:3-11 – "without hope" (verse 6); God does not care (verse 8) and "bitterness" (verse 11). Carlson (2005) describes Job 10:1-7 as Job's speech of depression:

My soul loathes my life; I will give free course to my complaint. I will speak of the bitterness of my soul. I will say to God, 'Do not condemn me; Show me why you contend with me. Does it seem good to You that You should oppress, that You should despise the work of Your hands, and shine on the counsel of the wicked? Do You have eyes of flesh? Or do You see as man sees? Are your days like the days of a mortal man? Are Your years like the days of a mighty man, that You should seek for my iniquity and search out my sin, although You know that I am not wicked, and there is no one who can deliver from Your hand?

It is clear that Job was dealing with depression based on the circumstances in his life. He went through many trials and is usually looked upon as a model of how people can get through troubling circumstances. He maintained his *faith* throughout all that happened to him (Job 42:1-6) and he was blessed as a result of his continuing faith in God (Job 42:12-15). Fleming (1994:183; cf. Helberg, 2006:16) states that although Job does not have the answer to his problems, he knows that God does – and God will not fail. God has not given Job any reason for his sufferings, but he has given Job a fuller knowledge of the all-powerful and all-wise God and this has changed Job's *thinking*. In the same way, depression sufferers should trust God to help change their thinking and renew their minds (Romans 12:2).

In every tragedy one can look at what one has lost and be hateful, or one can look at what one has left and be grateful (Gettys, 2005). Job chose to look at what he had left and be joyful. Life is not easy, and it would have been easy for Job to simply curse the Lord and die. But he did not do that. That is what the devil wants people to do. Gettys (2005) advises that if one is suffering from some disease, for example depression and anxiety, one should not curse God, leave His church, or turn one's back on Jesus Christ. Rather, one should stay close to Jesus. Job would have lost eternity had he given up on God. One must be faithful unto death, just like Job had been (cf. Revelation 2:10).

Often one suffers consequences for bad decisions and actions. Job's willingness to repent and confess known wrongs is a good example for people. Sometimes suffering shapes one for special service to others, or is an attack by Satan on one's life. Sometimes one does not know why one suffers. According to Green (1999:156) the explanation of the sufferings of God's children, as suggested by the case of Job, may be embraced in the following particulars. They afford to all gainsayers a palpable test of their integrity. The very intensity of the struggle develops their faith and other graces, and leads them on to clearer views of heavenly truths.

The following summarises Job's strengths, weaknesses and the lessons learned from his life (LASB, 2005:771):

Strengths and accomplishments

- A man of faith, patience, and endurance.
- Known as a generous and caring person.
- Very wealthy.

Weaknesses and mistake

- Allowed his desire to understand why he was suffering to overwhelm him and make him question God.

Lessons from his life

- Knowing God is better than knowing answers.
- God is not arbitrary or uncaring.
- Pain is not always punishment.

Suffering can be, but is not always, a penalty for sin (LASB, 2005:765). In the same way, prosperity is not always a reward for being good. Those who love God are not exempt from trouble. Although one may not be able to understand fully the pain one experiences, it can lead one to rediscover God. One must learn to

recognise but not to fear Satan's attacks because Satan cannot exceed the limits that God sets. One can always choose how one will respond to Satan's attacks.

Significance for depression sufferers

- Job was a man of prayer. Even in the midst of his suffering he turned to God. Depression sufferers can also find great comfort through *prayer*.
- Job's friends would have been of much more help to him by being silent. Sometimes, like in this case, silence and *listening* is better than speaking.
- Job maintained his *faith* throughout all that happened to him. In the same way, depression sufferers will do well to uphold their faith, even in the difficult times.
- God changed Job's *thinking*. Depression sufferers should, in the same way, trust God to help change their thinking and *renew their minds* (Romans 12:2).

c. Elijah

Elijah is a great example of how depression can strike even the boldest and most godly of men (Tan & Lyles, 2005:159; cf. Anderson & Anderson, 2004:107). Fowler (1999) highlights the following scriptural examples of Elijah's depression, discouragement and dejection: 1 Kings 19 – "fearful" (verse 3); suicidal (verse 4); and self-pitying (verse 14). Anderson and Anderson (2004:107) state that Elijah was afraid, fatigued and felt like a lonely, helpless failure; something which can happen to anyone today.

Elijah demonstrated both healthy and unhealthy responses to depression (1 Kings 19). According to Solomon (1998), Elijah was incapacitated with "depression" soon after he had been an integral player in one of the great demonstrations of God's power (1 Kings 19). The SCB (2001:781) states that after the great victory on Mount Carmel, his life was threatened and he became afraid. He focused on the *situation instead of on God*. During a sequence of events, he sank deeper and deeper into a state of depression. His fear became

so intense that he eventually ran away. House (1995:222) observes that for whatever reason – fatigue, lack of faith, or a sense of resignation at the prospect of never having peace – Elijah flees. Only then does one learn how acute is his mental anguish (Rice, 1990:157). He became so stricken he retreated to a cave and wanted to die (1 Kings 19:4).

Yet God – in contravention of the common belief among depressives that He is angry with or does not care about the depressed sufferer – came and ministered to Elijah's every need (Tan & Lyles, 2005:159; cf. Fleming, 1994:134). House (1995:222) shows how God began to renew Elijah's faith by miraculously feeding him. God provided him with food, sent angels to minister to his loneliness, and gave him a godly rest (cf. Rice, 1990:158). Elijah received God's loving care and was eventually restored in strength and purpose. Good mental health cannot totally be separated from one's physical health, which must be maintained with good nutrition, exercise, and rest (Anderson & Anderson, 2004:110). Depression and physical health affect each other – which came first however, cannot always be established. According to Fleming (1994:134; cf. House, 1995:223), God showed Elijah that although violent and spectacular events had some use, there would be lasting benefits only if people listened to God's voice in their hearts and responded accordingly (1 Kings 19:11-14). Tan and Lyles (2005:159) remark that God ministers the very same way today to anyone who suffers in the black places of depression.

Foster (1998:16) recounts that Elijah spent many a day and night in the wilderness learning to discern the "still small voice of Yahweh" (1 Kings 19:9-18). Elijah therefore spent a huge amount of time in *prayerful meditation*, trying to recognise God's voice, even from a pit of depression. According to LASB (2005:527), Elijah's single-minded commitment to God shocks and challenges people. He was sent to confront, not comfort, and he spoke God's words to a king who often rejected his message just because he brought it. Elijah chose to

carry out his ministry for God alone and paid for that decision by experiencing isolation from others who were also faithful to God.

It is interesting to think about the amazing miracles God accomplished through Elijah, but one would do well to focus on the *relationship* they shared. All that happened in Elijah's life began with the same miracle that is available to one – he responded to the miracle of being able to know God (LASB, 2005:527). For example, after God had worked an overwhelming miracle through Elijah in defeating the prophets of Baal, Queen Jezebel retaliated by threatening Elijah's life (LASB, 2005:527). In response, Elijah fled: he felt afraid, depressed, and abandoned. Despite God's provision of food and shelter in the desert, Elijah wanted to die. So God presented Elijah with an "audio-visual display" and a message he needed to hear. Elijah witnesses a windstorm, an earthquake, and fire. However, the Lord was not in any of those powerful things. Instead, God displayed his presence in a gentle whisper (LASB, 2005:527). The LASB (2005:527) explains that Elijah, like all people, struggled with his feelings even after this comforting message from God. Therefore God confronted Elijah's emotions and commanded action (cf. Rice, 1990:164). He told Elijah what to do next and informed him that part of his loneliness was based on ignorance: 7 000 others in Israel were still faithful to God.

Even today, God often speaks through the gentle and obvious rather than the spectacular and unusual (LASB, 2005:527). God has work for people to do even when they feel fear and failure. And God always has more resources and people than one knows about. Although one might wish to do amazing miracles for God, one should instead focus on *developing a relationship* with him. The real miracle of Elijah's life was his very personal relationship with God, and that miracle is available to people.

The following summarises Elijah's strengths, weaknesses and the lessons learned from his life (LASB, 2005:527):

Strengths and accomplishments

- Was the most famous and dramatic of Israel's prophets.
- Predicted the beginning and end of a three-year long drought.
- Was used by God to restore a dead child to his mother.
- Represented God in a showdown with priests of Baal and Asherah.
- Appeared with Moses and Jesus in the New Testament transfiguration scene.

Weaknesses and mistakes

- Chose to work alone and paid for it with isolation and loneliness.
- Fled in fear from Jezebel when she threatened his life.

Lessons from his life

- One is never closer to defeat than in one's moments of greatest victory.
- One is never as alone as one may feel; God is always there.
- God speaks more frequently in persistent whispers than in shouts.

Significance for depression sufferers

- After the victory at Mount Carmel, Elijah's life was threatened and he became afraid. He focused on the *situation instead of on God.* In difficult situations people tend to behave just like Elijah, but they should instead *focus on and trust in God*, to help them through the crises.
- God ministered to Elijah's every need. In the same manner God will aid the depression sufferer in *every* way – in contravention to the common belief among depressed people that God is angry with or does not care about the depressed sufferer.
- Good mental health cannot totally be separated from one's physical health, which must be maintained with *good nutrition, exercise, and rest.* This is especially important for the person struggling with depression.

- Elijah spent a huge amount of time in *prayerful meditation*. Depression sufferers can find great reassurance through *regular daily prayer*.
- God and Elijah shared a relationship. People who struggle with depression are encouraged to work on strengthening their *relationship with God*, even when God feels far removed from them.

d. David

According to Sutton and Hennigan (2001:41), King David, author of many of the Psalms probably struggled with depression. Fowler (1999) refers to the following scriptural examples of David's depression: Psalm 42 and 43 – soul in despair (42:6); disturbed (42:11); felt like God has rejected him; mourning (43:2); groaning all day long (Psalm 32:3); and groan in anguish of heart (Psalm 38:8).

According to LASB (2005:423), when one thinks of David, one thinks of a shepherd, poet, giant-killer, king and an ancestor of Jesus – in short, one of the greatest men in the Old Testament. Yet, alongside that list stands another: betrayer, liar, adulterer, murderer. The first list gives qualities all people might like to have, while the second gives qualities that might be true of any one of us. The Bible makes no effort to hide David's failures. Yet, he is remembered and respected for his heart for God (LASB, 2005:423). Knowing how much more one shares in David's failures than his greatness, one should be curious to find out what made God refer to David as "a man after my own heart" (Acts 13:22). According to LASB (2005:423) David, more than anything else, had an unchangeable belief in the faithful and forgiving nature of God. He was a man who lived with great zest. He sinned many times, but he was quick to *confess his sins*. Louw (2000:169) points out that coping with suffering, especially in the Old Testament, is often linked to the process of confession of sins and repentance. David's confessions were from the heart, and his repentance was genuine. David never took God's forgiveness lightly or his blessing for granted. In return, God never held back from David either his *forgiveness* or the consequences of his

actions. David experienced the joy of forgiveness even when he had to suffer the consequences of his sins (LASB, 2005:423). People tend to get the two reversed. Too often people would rather avoid the consequences than experience forgiveness. Another distinguishing characteristic of David is that while he sinned greatly, he did not sin repeatedly. He learned from his mistakes because he accepted the suffering they brought (LASB, 2005:423).

God knows how to get people's attention (Allender & Longman, 1995:153). Rather than let people wallow in the mediocrity of complacency, He lets them experience what it would be like to live without Him. Allender and Longman (1995:153) argue that He abandons people in order to shatter their illusions and then to lead them to a *deeper relationship* with Him. One sees this pattern again and again in Scripture, both on a corporate and individual level. According to Allender & Longman (1995:153) this pattern of redemptive abandonment can be seen on an individual level in Psalm 30, a prayer of thanks to God for salvation from death. While thanking God, David remembers the danger in which he was (verse 6-7). Allender and Longman (1995:154) point out that David remembered the complacency he felt as a resulted of the confidence he had in his own strength – prosperity and security had led to self-confidence (cf. Fleming, 1994:195). Nothing could happen to him: he was too good, too strong, too competent, and too powerful. However, when God abandoned David by "hiding his face", God stripped away from David his illusion of self-confidence. Allender and Longman (1995:154) indicate that predictably, the result of this abandonment was loss of hope: *depression*. Nevertheless, this depression did not drive David to self-pity; it drove him into the arms of God (verse 8-10). Fleming (1994:195) is of the opinion that God's shattering intervention was necessary to remind him that his security depended solely on God's grace. Allender and Longman (1995:153) explain that once again, the pattern moves from complacency, to abandonment, to *depression*, to greater glory – from stagnant relationship, to loneliness, to intimate fellowship (verse 11-12). Fleming (1994:195) observes that

when God had rescued him, *sadness* was replaced by joyful celebration, and *anxiety* was replaced by humble thanksgiving.

According to the SCB (2001:780), Psalm 102 provides a virtual checklist of symptoms that King David experienced during a particular stressful period in his life:

- "Let my cry come to You. Do not hide Your face from me in the day of my trouble." (Psalm 102:1, 2).
- He wrote of feeling stricken physically and described losing meaning and purpose in his life: "My days are consumed like smoke, and my bones are burned like a hearth. My heart is stricken and withered like grass." (Psalm 102:3, 4).
- He lost his appetite: "I forgot to eat my bread." (Psalm 102:4).
- He felt isolated and rejected: "I am like a pelican of the wilderness; I am like an owl of the desert." (Psalm 102:6).
- He could not sleep: "I lie awake." (Psalm 102:7).
- He had frequent crying spells: "I have eaten ashes like bread, and mingled my drink with weeping." (Psalm 102:9).

According to Anderson and Anderson (2004:68), David experienced classic symptoms of depression, including hopelessness, negative self-talk, sadness and thoughts of death. Even though he believed in God, David was depressed because what he believed about God was not true: how could an omnipresent and omniscient God forget David for even one minute, much less forever? Anderson and Anderson (2004:69) interpret "counsel in my soul" (Psalm 13:2) as nothing more than self-talk or mental rumination, which is unproductive. Finally, David asked God to enlighten his eyes, and by the end of Psalm 13, his reason had returned. David remembered that he trusted God's loving-kindness. Then he expressed hope that his heart should again rejoice, and he exercised his will by singing to the Lord (Psalm 13:6). One of David's secrets was that he *never gave*

up (Sutton & Hennigan, 2001:41). He never stopped trusting in God, no matter what his emotional state may have been at the moment. Fleming (1994:210) remarks that life is full of uncertainties (Psalm 102:23-24), but God's troubled people, from one generation to the next, (even those suffering from depression and anxiety) can depend on Him to rescue them and bless them (Psalm 102:27-28), because He is faithful.

The following summarises David's strengths, weaknesses, and the lessons learned from his life (LASB, 2005:423):

Strengths and accomplishments

- Greatest king of Israel.
- Ancestor of Jesus Christ.
- Listed in the Hall of Faith in Hebrews 11.
- A man described by God himself as a man after his own heart.

Weaknesses and mistakes

- Committed adultery with Bathsheba.
- Arranged the murder or Uriah, Bathsheba's husband.
- Directly disobeyed God in taking a census of the people.
- Did not deal decisively with the sins of his children.

Lessons from his life

- Willingness to honestly admit one's mistakes is the first step in dealing with them.
- Forgiveness does not remove the consequences of sin.
- God greatly desires one's complete trust and worship.

Significance for depression sufferers

- David had an unchangeable belief in the faithful and forgiving nature of God. He was quick to confess his sins. His confessions were from the heart, and his repentance was genuine. In the same way, depression sufferers should *confess their sins*, if this is the cause of their depression.
- Even though David believed in God, David was depressed because what he *believed about God was not true*. This is often the case with depression sufferers and they should be guided in *correcting their thinking.*
- David *never gave up*, even in the midst of all his struggles. Depression sufferers should remember that there *always is hope*, even from the black hole of depression.

e. Jeremiah

The final character which will be used as an example of how people in the Bible suffered from depression is Jeremiah. Jeremiah lived in the last days of a decaying nation (Stedman, 1966; cf. Brueggemann, 1988:1). He was the last prophet to Judah, the southern kingdom. Jeremiah's ministry covered about forty years, and during all this time the prophet never saw any signs of success in his ministry. His message was one of denunciation and reform, and the people never obeyed him. Kidner (1987:19) stresses that God's will was quite clear to Jeremiah, but at every point it would seem madness to his generation. He was called to a ministry of failure, and yet he was enabled to keep going and to be faithful to God and to accomplish God's purpose: to witness to a decaying nation.

Two important things are woven into the fabric of this entire prophecy. One concerns the fate of the nation, and the other concerns the feelings of the prophet (Stedman, 1966). Jeremiah constantly fought a battle against discouragement. He saw absolutely no signs of his ministry's success. When he was alone he was filled with discouragement, depression, resentment and

bitterness. Jeremiah expressed his feelings loudly and clearly (SCB, 2001:976). Jeremiah cried and mourned for the people of God. He was open to the heart of God because his own heart was open to God.

When the prophet was called back from a mire of depression and discouragement to the promise of God, he was reminded that *God is greater than circumstances* and when he got his eyes off himself and back on to God, he began to walk again (Stedman, 1966). Brueggemann (1988:3) described how Jeremiah's voice compelled people to rediscern their own situations, issuing an urgent invitation to *faith*, obedience, justice, and compassion.

Jeremiah had to depend on God's love as he developed endurance (LASB, 2005:1191). His audiences were usually antagonistic and apathetic to his messages. He was ignored and his life was often threatened. He saw both the excitement of a spiritual awakening and the sorrow of a national return to idolatry. Jeremiah responded to all of this with God's message and human tears. He expressed intense feelings, but he also saw beyond the feelings to the God who was soon to execute justice, but who afterwards would administer mercy. This prophet's life is an encouragement to faithfulness (LASB, 2005:1191).

Lamentations, written by the prophet Jeremiah, consist of five beautiful elegiac poems, one for each chapter (Dobson *et al.* 2005:912). These elegies, or songs of mourning, express the grief of the poet at the utter ruin of Jerusalem (cf. SCB, 2001:1034; Fleming, 1994:301; LASB, 2005:1283). SCB (2001:1034) describes Lamentations' five, short, tear-stained chapters as depicting the regrettable demise of God's rebellious people, while Baldwin (1984:7) points out that these five poems express grief, shock, humiliation and hope as people came to terms with disaster. Dirge poetry was not unique to Israel, but common in the ancient Near East. The Sumerians were the first to write dirge poetry over the destruction of some great city. The lament over Ur is one of the most celebrated elegies of the ancient Near East (Dobson *et al.* 2005:912).

LASB (2005:1283) emphasises that Jeremiah's grief ran deep. Called the "weeping prophet", his tears flowed from a broken heart. As God's spokesman, Jeremiah knew what lay ahead for Judah, his country, and for Jerusalem, the capital and "the city of God". God's judgment would fall and destruction would come (LASB, 2005:1283), and Jeremiah wept. His tears were not self-centred, mourning over personal suffering or loss, but he wept because the people had rejected their God – the God who had made them, loved them, and sought repeatedly to bless them. Jeremiah's heart was broken because he knew that the selfishness and sinfulness of the people would bring them much suffering and an extended exile. Jeremiah's tears were tears of empathy and sympathy. His heart was broken with those things that break God's heart. (LASB, 2005:1283).

According to LASB (2005:1283), what makes a person cry says a lot about that person, and particularly about whether he or she is self-centred or God-centred. The book of Lamentations allows people to see what made Jeremiah sorrowful. As one of God's choice servants, he stood alone in the depth of his emotions, his care for the people, his love for the nation, and his devotion to God.

Anderson and Anderson (2004:92) reminds the reader that one's hope in God is the anchor for one's soul and the answer for depression. Because God cannot lie, the basis for one's hope is found in the truth of His nature, character and Word. God cannot change, but one's perception of Him can, which can greatly affect how one feels (Anderson & Anderson, 2004:92). This is true of Jeremiah, who was depressed because of his skewed perceptions about God (Lamentations 3:1-6). Jeremiah believed that God was the cause of his physical and emotional hardships. He actually believed that God wanted to harm him, when in fact God wanted to restore him. Instead of being led by God, he felt like he was being driven to dark places where God had abandoned him (Anderson & Anderson, 2004:92). Lamentations 3:7-11 and 18 express Jeremiah's feelings of entrapment, hopelessness and fear.

Anderson and Anderson (2004:93) also explain that Jeremiah was depressed because his perception of God was wrong. God was not the cause of his affliction. God did not set up the circumstances to make his life miserable, but this was how Jeremiah perceived the situation, and consequently he lost hope in God. Yet, things changed suddenly (Lamentations 3:19-26). Nothing changed externally in Jeremiah's experience – the only thing that changed was his acknowledgement of God. He won the battle for his mind by recalling what he knew to be true about God. Hope returns when one chooses to believe the true nature and character of God, which is why it is necessary for one to worship God (Anderson & Anderson, 2004:93).

As a prophet, Jeremiah had predicted the fall of Jerusalem, but he wept at the fulfilment of his own prophecy (SCB, 2001:1034). After witnessing the devastation, darkness, and despair all around him (Lamentations 3:1-18), Jeremiah turned his eyes heavenward. According to Fleming (1994:302), the poet speaks in Lamentations 3 as if he is the representative of all Judah, describing Judah's sufferings as if they were his own. He feels hurt and depressed, yet in all the darkness of his suffering he now sees a ray of hope (verse 19-21). God may punish, but Jeremiah still trusts in him. He knows that God's steadfast love does not change, but is constant and reliable (Fleming, 1994:302). SCB (2001:1034) describes how Jeremiah found comfort in remembering that God keeps His covenants; He is filled with mercy, love, and goodness (Lamentations 3:22-24).

Foster (1998:16) has found that those who walked through the pages of the Bible knew the ways of meditation. Jeremiah discovered the word of God to be "a burning fire shut up in my bones" (Jeremiah 20:9). According to Brueggemann (1988:173) the prayer in Jeremiah 20:7-12 bears all the marks of a psalm of lament. Brueggemann (1988:175) further claims that this prayer is an act of weakness and of power: Jeremiah was aware that he was weak and helpless. He could not prevail, but he was confident that Yahweh *can* and *will* prevail.

Whitney (1991:188) stresses that a time of silence and solitude, seeking the salvation of the Lord is important. This may refer either to a non-Christian seeking salvation from sin and guilt in Christ or to a believer seeking *God's salvation from certain circumstances.* According to Whitney (1991:189), the words of Jeremiah in Lamentations 3:25-28 are appropriate in either case:

> *The Lord is good to those whose hope is in him, to the one who seeks him; it is good for a man to bear the yoke while he is young. Let him sit alone in silence, for the Lord has laid it on him.*

A person needs more discipline while he is young than in his mature years. Therefore, it is good for people to suffer in their youth, so that they may learn to exercise themselves in patient waiting upon the Lord (Dobson *et al.*, 2005:917). According to Fleming, God disciplines and trains, but those who are patient will enjoy the fullness of his salvation (3:25-27).

Since Lamentations looks back in mourning to the destruction of Jerusalem, as the book Jeremiah looked forward to that event with a solemn warning, Jeremiah's poetry forms a perfect sequel to his prophecy (Dobson, *et al.* 2005:912). Jeremiah's words of anger and grief teach people lessons about emotions as well as lessons about the ways in which people can communicate with God (SCB, 2001: 976).

Table 3.1 summarises the megathemes of Jeremiah and Lamentations (LASB, 2005:1187 and 1284):

Megathemes of Jeremiah and Lamentations (LASB, 2005:1187 and 1284)

Theme	Explanation	Importance
Sin	King Josiah's reformation failed because the people's repentance was shallow. All the leaders rejected God's law and will for the people. Jeremiah lists all their sins, predicts God's judgement and begs for repentance. Lamentations is a sad funeral song for the great capital city of the Jews. The temple has been destroyed, the king is gone, and the people are in exile. God had warned that he would destroy them if they abandoned him. Now, afterwards, the people realise their condition and confess their sin.	Judah's deterioration and disaster came from a callous disregard and disobedience of God. When people ignore sin and refuse to listen to God's warning, they invite disaster. Do not settle for half measures in removing sin. God's warnings are justified. He does what he says He will do. His punishment for sin is certain. Only by confessing and renouncing one's sin can one turn to him for deliverance. How much better to do so before his warnings are fulfilled.
Sin's consequences	God was angry at the prolonged rebellion by his people. Sin is the cause of their misery, and destruction is the result of their sin. The destruction of the nation shows the vanity of human glory and pride.	To continue in rebellion against God is to invite disaster. One must never trust one's own leadership, resources, intelligence, or power more then God. If one does, one will experience consequences similar to Jerusalem's.

Theme	Explanation	Importance
Punishment	Because of sin, Jerusalem was destroyed, the temple was ruined, and the people were captured and carried off to Babylon. The people were responsible for their destruction and captivity because they refused to listen to God's message.	Unconfessed sin brings God's full punishment. It is useless to blame anyone else for one's sin – one is accountable to God before anyone else. One must answer to him for how one lives.
God is Lord of all	God is the righteous Creator. He is accountable to no one but himself. He wisely and lovingly directs all creation to fulfil his plans, and he brings events to pass according to his timetable. He is Lord over the entire world.	Because of God's majestic power and love, one's only duty is to submit to his authority. By following his plans, not one's own, one can have a loving relationship with him and serve him with one's whole heart.
New hearts	Jeremiah predicted that after the destruction of the nation, God would send a new shepherd, the Messiah. He would lead them into a new future, a new covenant, and a new day of hope. He would accomplish this by changing their sinful hearts into hearts of love for God.	God still restores his people by renewing their hearts. His love can transform the problems created by sin. One can have assurance of a new heart by loving God, trusting Christ to save one, and repenting of one's sin.
Faithful service	Jeremiah served God faithfully for 40 years. During that time the people ignored, rejected, and persecuted him. Jeremiah's preaching was unsuccessful by human standards, yet he did not fail in his task. He remained faithful to God.	People's acceptance or rejection of one is not the measure of one's success. God's approval alone should be one's standard for service.

Theme	Explanation	Importance
God's mercy	God's compassion was at work even when the Israelites were experiencing the affliction of their Babylonian conquerors. Although the people had been unfaithful, God's faithfulness was great. He used this affliction to bring his people back to him.	God will always be faithful to his people. His merciful, refining work is evident even in affliction. At those times, one must pray for forgiveness and then turn to him for deliverance.
Hope	God's mercy in sparing some of the people offers hope for better days. One day, the people will be restored to a true and fervent relationship with God.	God's mercy in sparing some of the people offers hope for better days. One day, the people will be restored to a true and fervent relationship with God.

Table 3.1

The following list summarises Jeremiah's strengths, accomplishments and the lessons learned from his life (LASB, 2005:1191):

Strengths and accomplishments:

- Wrote two Old Testament books, Jeremiah and Lamentations.
- Ministered during the reigns of the last five kings of Judah.
- Was a catalyst for the great spiritual reformation under king Josiah.
- Acted as God's faithful messenger in spite of many attempts on his life.
- Was so deeply sorrowful for the following condition of Judah that he earned the title "weeping prophet".

Lessons from his life

- The majority opinion is not necessarily God's will.
- Although punishment for sin is severe, there is hope in God's mercy.
- God will not accept empty or insincere worship.

- Serving God does not guarantee earthly security.

Significance for depression sufferers

- Jeremiah's heart was open to God. Depression sufferers can find hope and comfort by *opening up their hearts and minds to God.*
- Jeremiah was reminded that *God is greater than circumstances.* In the same way the depression sufferer can be assured that God is greater than their every need and circumstance.
- Jeremiah had to depend on *God's love* as he developed endurance. This is true for every person.
- This prophet's life is an encouragement to *faithfulness.*

f. Conclusion

Many biblical figures suffered from anxiety and depression and often experienced or expressed it in harmful ways. In this chapter only Moses, Job, Elijah, David and Jeremiah were discussed, although there are many other biblical examples of people who struggled with anxiety and depression. They frequently developed health problems and expressed anger with God. Yet, God spoke to them, like many other biblical figures, not because they had special abilities, but because they were willing to listen to Him.

Perspectives from the Old Testament regarding mood and anxiety disorders were discussed above. The perspectives regarding anxiety and depression from the New Testament will follow in the next sections.

3.4 ANSWERS TO DEPRESSION SUFFERERS FROM 2 CORINTHIANS 1:3-11 AND PHILIPPIANS 4:4-13

The following expositional studies of 2 Corinthians 1:3-11 and Philippians 4:4-13 will provide depression sufferers with answers in overcoming their depression and anxiety. This will be expounded in chapter five.

3.4.1 Expositional study of 2 Corinthians 1:3-11

When Paul learned that neither his lengthy letter nor Timothy's recent visit had brought any improvement in the Corinthian church, he made a trip to Corinth direct by boat. This was only Paul's second visit to Corinth. It gave him such distress that when he looked back on it later he referred to it as a painful visit (Fleming, 1994:515). Paul wrote 2 Corinthians to defend his position and to denounce those who were twisting the truth (LASB, 2005:1942). The chief element of value in this epistle is the revelation it gives of the apostle himself. Through all its changing moods, Paul, in perfect abandon, shows his very soul, suffering, rejoicing, enduring, and overcoming.

Paul experienced great suffering, persecution, and opposition in his ministry. He even struggled with a personal weakness, which he described as a "thorn in the flesh". Through it all, Paul affirmed God's faithfulness (LASB, 2005:1943). God is faithful. His strength is sufficient for any trial. When trials come, they keep one from pride and teach one dependence on God. He comforts one, so that one can comfort others.

According to Hindson and Dobson (1999:1559), Paul wanted the believers in Corinth to know that Jesus Christ is the tender and loving saviour who's comfort will overflow in people's lives as people get to know him (2 Corinthians 1:5). Furthermore, the Lord will also provide people with the grace they need to make it through any situation in a way that honours Him (2 Corinthians 12:9).

To encourage the Corinthians as they face trials, Paul reminded them that they would receive new bodies in heaven. This would be a great victory to their present suffering, as the promise of new bodies offers hope. No matter what adversity one faces, one can keep going. One's faithful service will result in triumph (LASB, 2005:1943).

Blessed (2 Corinthians 1:3a): The Greek word *eulogetos* means "well spoken of". According to Dobson *et al.* (2005:1505), this term is used in the New Testament of God. It is a term of adoration and praise. In consideration of God's grace and peace (verse 2) and in anticipation of His mercies and comforts (vs. 3b), such a pronouncement from the apostle is understood (Dobson *et al.* 2005:1505), for he contemplates both who God is, and what God does.

(Blessed) Be the God and Father of our Lord Jesus Christ, the Father of mercies, and God of all comfort (2 Corinthians 1:3b): Garland (1999:58) argues that Paul launches his letter with a classic Jewish liturgical formula that praises God for his benefits. Had Paul not identified God as the Father of Jesus Christ, this benediction would have had a familiar ring in the synagogue but would also have been jarring. According to Garland (1999:58) the synagogue blessed the God of our fathers, who revealed himself to Moses as "I am who I am" (or "I will be who I will be"; Exodus 3:14). For Christians God is now revealed as the God and Father of our Lord Jesus Christ. This affirmation has two implications. First, as the Father of Jesus Christ, God is no longer to be known simply as the Father of Israel. Through Jesus Christ all, both Jew and Greek, have access to the Father (Ephesians 2:18). One can only truly know God as the Father of Jesus Christ. Second, according to Garland (1999:59), it declares that Jesus is the foremost blessing God has bestowed on humankind (Colossians 1:12). Dobson *et al.* (2005:1505) indicate that the mercies in view here include such great verities as deliverance from the world, sin, and Satan to participation in sonship, light, and life. The force is even more than this: for Dobson *et al.* (2005:1505) the stress is that the Father is "characterised" by mercy (cf. Psalm

86:5; Daniel 9:9; Micah 7:18). For Garland (1999:59) the *mercies* and *comfort* are brought to realisation through Christ (2 Corinthians 1:5).

Comfort (Greek: *paraklesis*) is cognate to "the Comforter" of John 16:7. Garland (1999:60) remarks that Paul's use of the *paraklesis* word group (*comfort, consolation, appeal*) predominates in 2 Corinthians (twenty-nine out of fifty-nine instances in the New Testament). The verb had a variety of uses in the New Testament. According to Garland (1999:60) it was used for making an earnest appeal, for consoling or comforting someone who is distraught, for admonishing another (to renounce), or for making amends (to apologise). This term does not connote "sympathy" as much as "empathy" or "encouragement" (Dobson *et al.* 2005:1505). It has the idea of someone coming alongside to provide support. Garland is of the opinion that the word *comfort* may denote *emotional relief* and a sense of *well-being, physical ease, satisfaction*, and *freedom from pain and anxiety*.

Since the Comforter abides within (cf. John 14:16-17), a twofold process is implied according to Dobson *et al.* (2005:1505): Strength for the *inner* man and encouragement for the outer man. Paul now turns his thoughts to the everyday problems of life and he does so in the context of the **God of all comfort; who comforts us in all our tribulation** (2 Corinthians 1:3c-4a). Dobson *et al.* (2005:1505) have found that in the general scope of life, God's comfort extends to every area. But the purpose emphasized here is not just for our one's good, but **that we may be able to comfort those who are in any trouble** (v. 1:4b). God's comfort is transferable and intended to be shared. Garland (1999:60) agrees and states that the comfort that Paul has in mind has nothing to do with a languorous feeling of contentment. It is not some tranquilising dose of grace that only dulls pains but a stiffening agent that *fortifies* one in *heart, mind*, and *soul*. Comfort relates to encouragement, help, and exhortation. God's comfort strengthens weak knees and sustains aging spirits so that one faces the trouble of life with unbending resolve and unbending assurance (Garland, 1999:60).

Significance for depression sufferers

- People can find *comfort in God* when they are suffering from depression and anxiety.
- It is important to understand that Jesus Christ, the Father of mercies, consoles and encourages people even when emotionally distraught.
- As God comforts people in their tribulations, they need to *comfort and help others*. In fact, an individual that is depressed can help to relieve his/her own depression by getting out and helping someone else.

For as the sufferings of Christ abound in us, so our consolation also abounds through Christ (2 Corinthians 1:5): Garland (1999:65) interprets it as that Paul offers an explanation ("because", *hoti*) of *how* he is able to comfort others through his affliction (1:3). In describing his sufferings in Christ, Paul pictures a balance sheet of two columns: sufferings of Christ versus comfort through Christ. According to Garland (1999:65), ministering in this present evil age brings him a surplus of suffering that becomes almost unbearable. However, the consolation column also shows a surplus, and it more than balances the suffering. Dobson *et al.* (2005:1505) show that as the problems increase so does the consolation. Both, in this case, are measured by the experience of Christ (cf. Luke 24:26, 46; Philippians 3:10; Colossians 1:24; 1 Peter 1:11). Paul's use of the term *abound* is significant throughout this epistle (cf. 2 Corinthians 4:15; 8:2, 7-8, 12).

According to Dobson *et al.* (2005:1505) many ancient manuscripts differ in the order of the clauses in 2 Corinthians 1:6-7. But the sense in every case is basically the same: "if we are afflicted, it is for your good, or if we are comforted, it is for your good." Everything else in these verses is subordinated to these two main ideas (Dobson *et al.*, 2005:1505). Paul does not glory in suffering, *per se,* but he knows that the fact of suffering identifies one with Christ and with His church (cf. Romans 8:17). Garland (1999:67) points out that 2 Corinthians 1:6

explains how Paul can comfort those in any affliction (cf. 2 Corinthians 1:4b). The "same sufferings", according to Garland (1999:68) refer to "the sufferings of Christ" (v. 1:5). Paul believes that all those connected to Christ crucified will experience suffering, and he implies that they should therefore not disparage Paul for his suffering. They share these sufferings because they share Christ and because they live in a fallen world, ruled temporarily by malevolent powers that have pitted themselves against God. Those who proclaim the gospel boldly and stand up against all God's adversaries should anticipate suffering.

God never promised that people will never suffer since they live in a fallen world. However, they will receive more consolation than the suffering they will ever endure.

Paul also knows **that as you are partakers of the sufferings, so also you will partake of the consolation** (v. 7). Garland (1999:69) feels that the sufferings refer to the sufferings of Christ. Since the sufferings are connected to Christ, they will receive the same wealth of consolation that Paul has received. Since they share Christ, they share His sufferings, and since they share His sufferings, they also share Christ's comfort. Dobson *et al.* (2005:1505) conclude that if people should suffer together, then they know that they will also rejoice together. Those who share mutual suffering and affliction share also in the joy of consolation. Dobson *et al.* (2005:1505) go on that this relationship of intimacy implied by the apostle's terminology stands in stark contrast to the disruptive spirit that persisted in Corinth (cf. Garland, 1999:69). His readers could not help but compare their own situation against the feelings and experiences expressed by Paul.

In 2 Corinthians 1:8-10 Paul draws upon his recent experience to do two things: to share with his readers his needs and concerns, and also, to explain his change in plans (Dobson *et al.*, 2005:1505). Piper (1997) states that in 2 Corinthians 1:8-11 Paul tells the church at Corinth about his unbearable experience in Asia and what God's purpose was in it and what he anticipates in the future because of it.

According to Garland (1999:72), Paul here gives an example of his experience of affliction and God's comfort. He can quote the evidence when time and again God has been faithful to deliver him. Paul gives no details about what this affliction in Asia was. He only explains that the depth of the great danger he faced in Asia was matched by the depth of his gratitude to God for his deliverance (Garland, 1999:73). Paul wants to inform the Corinthians what his affliction and deliverance means theologically in hope that it will deepen their relationship with him and increase their thanksgiving for the grace bestowed on him by God (v. 1:11).

Significance for depression sufferers

- Suffering has a *purpose* in people's lives, even though this does not make sense.
- People will suffer since they are one with Christ who suffered on the cross.
- Paul experienced serious affliction in Asia from which God delivered him and comforted him. In the same way, God will comfort those who are afflicted with depression and anxiety.

The expressions **we despaired even of life** (v. 8) and **we had the sentence of death in ourselves** (v. 9a) are parallel concepts. According to Dobson *et al.* (2005:1505), Paul's condition, due to external pressures and physical limitations, reached the point where the only way out visible to him, was death. Yet God's purpose, even in this, was being fulfilled so that Paul would come to the end of himself and trust in **God who raises the dead** (v. 9c). For Paul has initiated a process of *faith* that is viewed in a threefold sense, ... **who delivered us** (v. 10a, past) ... **and does deliver us** (v. 10b, present) ... **He will still deliver us** (v. 10c, future). Faith liberated Paul from bondage to his circumstances and the fear of death (cf. Hebrews 2:14-15).

2 Corinthians 1:9-10 shows that God had two purposes for bringing Paul to a point where he was unbearably crushed (Piper, 1997). First, he says in verse 9 **"that we should not trust in ourselves but in God who raises the dead."** In other words, God brought Paul so close to death that there could be no more hope in this life but only in the resurrection. And His aim was to put an end to the self-confidence in Paul – to make Paul feel that in the things that really count man is of no help; only God is. Louw (2000:181) argues that a suffering believer's power is not derived from him/herself, but "externally" from a transcendental source. Depression sufferers should focus on and trust in God and not on their circumstances and their own abilities. God will deliver them from their suffering. Trust in God will be included as an important element of phase two of the model proposed in chapter five.

Garland (1999:80) indicates that the use of the present participle *raises* means that Paul understands this to be a permanent attribute of God (cf. Romans 4:17). His basic conviction according to Garland (1999:80) is that in Christ God "has destroyed death and has brought life and immortality to light through the gospel" (2 Timothy 1:10, cf. 1 Corinthians 15:21, 26, 54-57). God is the one who comforts (v. 1:4) and the one who raises the dead. According to Piper (1997), *suffering* is intended by God to bring to people's attention and make them feel what is true *all the time*, namely, that they are finite creatures absolutely dependent on God for absolutely everything. God's will is that they know it, feel it, and live like it. That is his first purpose in bringing Paul into unbearable circumstances (Piper, 1997). One can only experience God's power when one has become utterly *weak* and *despairing* of any human solution (Garland, 1999:81; cf. Fitzpatrick, 2002:179). God raises those who are dead, not those who are already exalted. God's power is made perfect in the *weakness* of the cross of the Son, and that divine pattern of working in the world continues in the cruciform ministry of his apostle. Garland (1999:81) observes that this wonderful affirmation of *faith* is Paul's opening salvo for deconstructing the Corinthians' worldly mindset.

His second purpose, according to Piper (1997), is mentioned in verse 10: "**who delivered us from so great a death, and does deliver us; in whom we trust that He will still deliver us**". In Paul's case God aimed to deliver him after He had purged him of self-confidence. And so Paul is moved to have hope in God not only for resurrection after death but also to hope in Him for deliverance from death. Piper (1997) indicates that having taught Paul that he need not be delivered from death in order to trust in God since God raises the dead, nevertheless, God does deliver Paul from death. And so Paul is encouraged that God must yet have things for him to do and he is hopeful that God will go on preserving him for those things. For Garland (1999:82), the emphasis in verse 10 is Paul's fundamental confidence that God *will* deliver him. The prayers of the Bible that praise God as a deliverer have clearly influenced Paul's language here (1 Samuel 22:2, Psalms 18:2-6, 32, 38, 40:17, 70:5, 72:12, 91:15, 116, 140:7, 144:2). Paul is confident that God will continue to deliver him, but the verdict of death has not been removed. His hope is set on God's final deliverance from death (Garland, 1999:82).

Piper (1997) maintains that there is a great lesson to be learned here that will help people to understand what God is doing in their daily lives and that will help them pray about their circumstances as they ought to. The lesson is this: God always aims to *glorify* Himself in one or both of these ways in one's experience of *adversity*. He always aims to wean people away from relying or trusting or hoping in any help but Him alone (cf. Psalm 131). According to Piper (1997), adversity by its very nature is the removal of things on which one's comfort and hope have rested and so it will either result in *anger* toward God or greater *reliance* on Him alone for one's *peace*. His purpose for people in adversity is not that they get angry or discouraged but that their hope shift off earthly things onto God. God's main purpose in all adversity is to make people stop trusting in themselves or any other person (Piper, 1997). The word resounds through the Old Testament (cf. Jeremiah 17:5, Psalm 33:16-18, Psalm 60:11, Psalm 146:3, Proverbs 19:21, Proverbs 21:31, Isaiah 2:22).

According to Piper (1997), the whole Bible wants to teach people the lesson of 2 Corinthians 1:9: that people should not pin their hopes on other people or on anything this world can offer. People have to look to God for their *hope*, their *joy*, their *fulfilment*, even in death for He is the God who raises the dead. If they *trust* Him like that He will be greatly glorified and that is His first purpose in their adversity.

The second half of the lesson here is that God often glorifies Himself by delivering from death those whom He has taught not to fear death (Piper, 1997). God receives praise when His people die in *peace*, *trusting* Him. God receives praise when He delivers His people from death. Which He shall choose, lies in His secret counsels and whether He has more work for them to do – He will deliver them for his evangelistic work until His purpose is complete. Piper (1997) writes that God brings people into adversity to glorify Himself by making them *hope* more fully in Him and then by delivering them from that very adversity until His purpose for them here is done.

Significance for depression sufferers

- Depression sufferers should *not trust in themselves, but in God.*
- God uses suffering to lead people to Him, to make them understand that they are dependent on Him in *all circumstances*.
- People realise God's power when he delivers them from pain and provides them with peace when experiencing difficult circumstances.

Frequently in Paul's letters, the Greek word translated *gracious gift*, is associated with the Spirit (Fee, 1999:286). But as noted in 1 Corinthians 7:7, the concept of *spiritual gift* is additional to the word, not inherent to it. In the case of 2 Corinthians 1:11 it is most likely understood as the gracious activity of God on Paul's behalf in rescuing him from a deadly peril, from which at one point he did

not expect to recover. It apparently refers to Paul's recovery from some debilitation, sickness or otherwise, that has caused him to despair of life itself.

Garland (1999:82) notes that in 2 Corinthians 1:11 Paul believes that deliverance comes through *intercessory prayer.* The verb *synypourgeo* means "to work together with" or "cooperate" by means of something, in this case, by means of their prayers on his behalf. Paul does not pretend that he can survive well on his own without help from anyone else. He has no qualms about expressing his desperate need for their prayers. According to Garland (1999:82), Paul is firmly convinced of prayer's power because he knows that God listens, responds and delivers.

Significance for depression sufferers

- Just like Paul needed the prayers of the church, people struggling with depression need others to pray for them. *Christians should pray for each other.* Depression sufferers can often not survive well on their own and find comfort if others *intercede* on their behalf.
- *Prayer* is also regarded as an essential part of any treatment model for depression sufferers (this will form an integral part of the model proposed in chapter five).

Helping together (2 Corinthians 1:11) probably has reference to their cooperation in interceding in his behalf with the other churches. According to Dobson *et al.* (2005:1505), Paul's thinking in this verse is very much like that in verses 6-7. Since there were many who were sharing together in **prayer for us**, the fact of Paul's deliverance may also elicit **thanks ...by many on our behalf** (cf. Garland, 1999:82). The preposition **by** (Greek: *dia*) is best rendered "by means of". Thus the sense of the verse is: as health was rendered by means of prayer so also *thanksgiving* to God is rendered by means of many who shared in that prayer (Dobson *et al.* 2005:1505; cf. Garland, 1999:82). Paul's ultimate

concern here, according to Garland (1999:83), is not his rescue from danger but that God will be honoured more and more – the pattern of suffering and deliverance therefore drives him further into the arms of God.

Significance for depression sufferers

- As God comforts people in their tribulations, they need to comfort and help others.
- There is no doubt that prayer is very powerful in addressing every situation of life including emotional suffering.
- An individual that is depressed can help to relieve his own depression by reaching out and helping someone else.

Piper (1997) expresses the opinion that having told the Corinthians in verses 9 and 10 what God's purposes were in his unbearable affliction, he calls on the church (verse 11) to pray for him that those purposes might in fact come about. Piper (1997) calls this "*the line of prayer*":

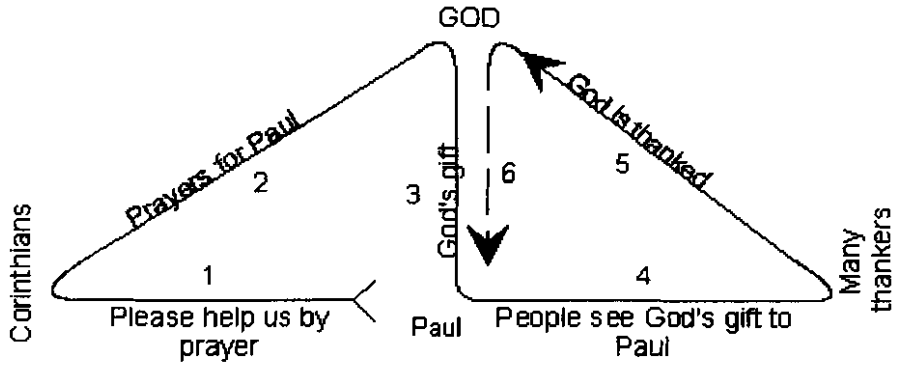


Figure 3.1

This process begins in the heart of Paul. He feels a need for help in his life: to rely more on God and to be delivered from the many people who were against him in his ministry. Thus, he sends out a *line* of appeal to the Corinthians:

"Please help us by prayer." That is *stage 1* in the line of prayer: a request by Paul to the Corinthians.

Then the line of prayer curves up through the hearts of the Corinthians as they respond to Paul's plea and send up their prayers for Paul to God. Paul asks for prayer and so the Corinthians pray. That's *stage 2* in the line of prayer.

Thereafter the line of prayer enters the heart of God and in response to the many prayers of the Corinthians He gives a gift or a blessing to Paul. In this case, the blessing is probably deliverance from some peril or threat as well as the ability to rely fully on God through trial. This answer of God to the Corinthians' prayers is *stage 3* in the line of prayer: "Please help us by prayer," stage 1. Many Corinthians pray for Paul, stage 2. God answers their prayers, stage 3.

Just like many heard that Paul had a need, so also many see that, in response to many prayers, God has met Paul's need. People are awake to God's working and are aware of His gifts to Paul. That is *stage 4* in the line of prayer.

In response to what they have seen these people turn their faces to God and give Him thanks for blessing Paul in such a remarkable way in answer to so many prayers. In this way, the line of prayer curves up through their grateful hearts toward God again. *Stage 5* in the line of prayer, then, is that God is thanked on behalf of Paul for the blessing granted to him in answer to many prayers.

The text stops with God being thanked by His people for His gracious answer to many prayers, but Piper (1997) has added a 6th stage, with a dotted line, which he thinks is necessarily implied. The very fact that Paul tries to motivate the Corinthians to pray for him by showing them that this will result in God being thanked by many people indicates that Paul delights in the thought of God being thanked. This is what he lives for: that many people will glorify God through

genuine gratitude. So *stage 6* of the line of prayer is the joy that comes back to Paul when he sees God glorified in the praises of His people.

Table 3.2 summarises the megathemes of 2 Corinthians (LASB, 2005:1943):

Theme	Explanation	Importance
Hope	To encourage the Corinthians as they faced trials, Paul reminded them that they would receive new bodies in heaven. This would be a great victory in contrast to their present suffering.	To know one will receive new bodies offers one hope, No matter what adversity one faces, one can keep going. One's faithful service will result in triumph.
Trials	Paul experienced great suffering, persecution, and opposition in his ministry. He even struggled with personal weakness – a "thorn" in the flesh. Through it all, Paul affirmed God's faithfulness.	God is faithful. His strength is sufficient for any trial. When trials come, they keep people from pride and teach them dependence on God. He comforts one so one can comfort others.

Table 3.2

In conclusion, God is the Father of mercies, and God of all comfort. If people are afflicted, it is for their good, or if they are comforted, it is for their good. The word "comfort" may denote *emotional relief* and a sense of *well-being, physical ease, satisfaction*, and *freedom from pain and anxiety.* Those who share mutual suffering and affliction share also in the joy of consolation. For people in despair

prayer is powerful because God listens, responds and delivers. Deliverance comes through *intercessory prayer.*

3.4.2 Expositional study of Philippians 4:4-13

The apostle Paul wrote the New Testament letter to the church at Philippi while he was a prisoner in Rome awaiting trail (Philippians 1:7; cf. Lenski, 1961:697). Despite his dire circumstances, Paul's tone is unabashedly joyful (SCB, 2001:1562). His experience reminds one that joy comes from God and transcends mere happiness. Lenski (1961:691) states that the whole epistle radiates joy and happiness. Joy survives one's trial and is the perfect antidote to fear and anxiety (Philippians 4:4-6). Paul was able to face tough challenges because he was radically committed to a Christ-centred life. According to Carson and Moo (2005:512), the letter reveals something of the apostle's satisfaction when his converts made progress in the faith. Paul rejoices that the gospel be preached, and the note of joy is sounded throughout this letter; it is important for Christians to be a rejoicing people.

Another significant aspect is what Paul calls "partnership" in the gospel (Philippians 1:5). Paul encourages his friends, assures them of his affection for them, teaches them lessons from his own circumstances and adds to their knowledge of the Christian way (Carson & Moo, 2005:512). It is a beautiful picture of Christian harmony. Paul stresses the place of the cross and the resurrection in Christian salvation. The suffering of the Christian fits in with this. Paul draws attention to the way the gospel is advanced through his own sufferings (Philippians 1:14-18) and he sees the sufferings as God's gift to them (Philippians 1:29-30). The important issue is the service of Christ. At the end of the letter, he records his magnificent assurance that "my God will meet all your needs according to the riches of His glory in Christ Jesus" (Philippians 4:19).

The letter to the Philippians provides many insights about suffering, hope and encouragement for depression sufferers. Philippians 4:4-13 is especially helpful in this regard and will now be discussed in more detail.

3.4.2.1 Rejoicing in Christ's Peace (Philippians 4:4-9)

In greetings to people who have worked with Paul, the apostle in Philippians 4:4-7 calls on them to rejoice in the Lord, and encourages them to pray without anxiety but with the assurance that God's peace will guard people (Carson & Moo, 2005:498). In Philippians 4:8-9 he encourages them to practice Christian virtues wholeheartedly. Lenski (1961:874) observes that verses 4-9 are added without a connective and present a lovely picture of the temper, the quality, and the motivation of all true Christian hearts.

Rejoice in the Lord always. Again I will say, rejoice! (Philippians 4:4): The Christian is not gloomy, but glorious. According to Dobson *et al.* (2005:1597; cf. Lenski, 1961:875) the keynote of this book is *joy*. Paul exhorts them to keep on *rejoicing*. Lenski (1961:875) points out that the imperative *rejoice* is repeated, for the whole stress is on this activity of the heart. According to Hendriksen (1973:192) the exhortation is repeated, probably because on the surface it seems so unreasonable to rejoice in *obedience to a command*, and perhaps even more unreasonable to rejoice *always*, under all circumstances no matter how trying. Wright (2004:130) expresses the fact that normally in today's time, the word *rejoice* is understood as meaning something that happens inside people, a sense of joy welling up and making them happy from within. All that is important and it is contained within Paul's command; but in his world and culture this rejoicing would have meant (what today would be called) public celebration. The world all around, in Ephesus, Philippi, Corinth and elsewhere, used to organise great festivals, games and shows to celebrate their gods and their cities, not least the new "god", Caesar himself. Why should the followers of King Jesus not celebrate

exuberantly? Wright (2004:130) argues that this is only right; and celebrating Jesus as Lord encourages and strengthens loyalty and obedience to him.

Paul kept on rejoicing, whether he were in prison or in the palace; in prosperity or in adversity; in health or in sickness (Dobson *et al.* 2005:1597; cf. 2 Corinthians 12:10). Joy is a fruit of the Spirit (cf. Mitchell, 2004:42) and is the result of *peace* with God (Romans 5:1-2). Joy drives out discord and is contagious. Christians rejoice because they are in living union with Christ.

Significance for depression sufferers

- Christians can experience *joy* since they live in the *peace of God.*
- Celebrating Jesus Christ as Lord inspires people to live in *obedience* to Him.
- Even whilst suffering, people can still have joy knowing that they are living in union with Christ.

Let your gentleness be known to all men (Philippians 4:5a): Dobson *et al.* (2005:1597; cf. Hendriksen, 1973:193) explain that this point towards one's forbearance, considerateness, graciousness, overlooking the faults and failures of others (cf. Lenski, 1961:875). This is the opposite of stubbornness and thoughtlessness. Wright (2004:130) remarks that it is interesting that Paul once says that the public image of the Christian church should be of a gentle, gracious community (verse 5). Exuberance must not turn into mere extrovert enthusiasm which squashes sensitive souls and offends those who are by nature quiet and reserved.

Significance for depression sufferers

- People should be *sympathetic* towards others despite their faults, abnormalities or mistakes.
- A Christian should be known as a gentle person caring for others.

The Lord is at hand (v. 4:5b): The Lord is always available to people, even in desperate times.

Be anxious for nothing (Philippians 4:6a): Stop being *anxious* and so not have the habit of *worrying*. According to Hendriksen (1973:195), this indicates *to be unduly concerned about, to be filled with anxiety, to worry*. Foster (1998:194) interprets this as the negative side of rejoicing. Anxiety was a way of life for many in the ancient pagan world (Wright, 2004:131). With so many gods and goddesses, all of them potentially set on harming people for some offence they might not even know about, people never knew whether something bad was waiting for them just round the corner. With the God who had now revealed himself in Jesus, there was no guarantee against suffering, but there was the certainty that this God was ultimately in control and that he would always hear and answer prayers on any topic whatever. According to SCB (2001:1567) Paul certainly had plenty of reasons to feel *anxious*. Locked in a Roman prison, he did not know if he would be released or put to death. Writing to the believers in Philippi, however, he urged them, "Be anxious for nothing."

Significance for depression sufferers

- Despite one's outside circumstances, with God, one can still be in *charge of one's inside feelings* which provides hope for people suffering from depression and anxiety.

According to Foster (1998:194), Paul instructs people on how they can always rejoice, and his first word of counsel is to be "full of care" for nothing. Jesus, of course, gives the same advice when he says, "Do not be anxious about your life, what you shall eat or what you shall drink, nor about your body, what you shall put on." (Matthew 6:25). In both instances the same word is used, which can be translated *anxious* or *careful*. According to Lenski (1961:877), the Christian is never to worry about a single thing. Foster (1998:194) points out that Christians

are called to be free of care, but people find such a way foreign to them, because they have been trained since they have been two years old to be full of care.

Anxiety and its companion *worry* do their best to debilitate believers (SCB, 2001:1567). Anxiety causes physical problems. It makes people fearful and distressed. Paul gives the answer for anxiety: "In everything by prayer and supplication with thanksgiving, let your requests be made known to God." (Philippians 4:6). Anderson and Miller (1999:67) explain that the *minds* of those struggling with anxiety disorders are riddled with contaminated thinking and erroneous thoughts of themselves, God, and their circumstances of life. Anderson and Miller (1999:67) further explain that connecting with God through genuine repentance and renewing of one's mind (Romans 12:2) to the truth of his Word will result in the born-again Christian experiencing "the peace of God". When people give their anxiety to God, He replaces it with his peace that "surpasses all understanding" (SCB, 2001:1567; cf. Anderson & Miller, 1999:67). God's *peace* is beyond comprehension because it makes no sense – the circumstances seem to require anxiety, but instead one feels God's *peace*.

Wright (2004:131) finds that people are hesitant to bother God with trivial requests (fine weather for the church picnic; a parking space in a busy street); but, though of course one's intercessions should normally focus on serious and major matters, one notes that Paul says one should ask God about *every* area of life. If it matters to a person, it matters to God. Prayer like that will mean that God's peace – not a Stoic lack of concern, but a deep peace in the middle of life's problems and storms – will keep guard around your heart and mind, like a squadron of soldiers looking after a treasure chest (Wright, 2004:131). In days of tension and trouble, in days of frustration and failure, instead of *worrying*, take it to the Lord in prayer (Dobson *et al.*, 2005:1597). Hendriksen (1973:195) states that the cure for worry is prayer.

Significance for depression sufferers

- Christians should avoid anxiety since it debilitates believers and has a negative impact on their thinking.
- One way to conquer anxiety is to make one's concerns known to God through *prayer.*
- One should also focus on and thank God for past blessings, including their occasional sufferings, trusting that he will use all their experience as a means for their edification.

But in everything by prayer and supplication, with thanksgiving, let your requests be made known to God (v. 4:6b): According to Foster (1998:194), this is the positive side of rejoicing. Prayer is the essence of worship and devotion. Supplication is entreating, earnest pleading for personal needs. Dobson *et al.* (2005:1598) note that prayer is a general term; supplication is definite and detailed. Thanksgiving should always accompany a prayer or a petition. Thanksgiving for past blessings is good preparation for successful supplications. Care and prayer are mutually opposed. One should be *anxious* for nothing, prayerful for everything, and thankful for anything (Dobson *et al.* 2005:1598): "Casting all your care upon him; for he cares for you" (1 Peter 5:7). Hendriksen (1973:195) points out that the proper antidote for anxiety is the outpouring of the heart to God.

According to Lenski (1961:878), Paul's very words in Philippians 4:6 contain the assurance that God will attend to all that one asks by either giving this to one or giving one something better above what one asks or thinks. One's prayer and one's petition will naturally be accompanied by "thanksgiving" and will thus be offered with constant joy. Lenski (1961:878) adds that only the thankful heart is a joyful heart. The heartthrob of all true prayer is thankfulness.

Meyer (2002:124) mentions that Philippians 4:6 is a good Scripture to consider when a "worry attack" comes. She highly recommends speaking the Word of God out of the mouth. It is a two-edged sword that must be wielded against the enemy (Hebrews 4:12, Ephesians 6:17). Meyer (2002:124) also adds that God has given man His Word and it is there to be used. Collins (1993:55) states that one can bring one's anxiety to God in prayer, be reminded that He is near to one, and expect that one will experience genuine inner peace, even in the midst of one's suffering (Philippians 4:5-6).

And the peace of God (Philippians 4:7a): Dobson *et al.* (2005:1598) explain that this is more than peace *with* God (Romans 5:1); it is a peace which God *has* and which Christ *gives* (John 14:27). Lenski (1961:879) explains that "of God" indicates source: God creates and bestows this peace (cf. Hendriksen, 1973:196). Dobson *et al.* (2005:1598) also remark that the peace of God comes to a child of God who *trusts* and *prays*. All Christians have peace with God, and all Christians may have the peace of God, that is, inward tranquillity of soul grounded in God's presence, God's promise, and God's power. One may have peace with God without having the peace of God. *Peace with God is dependent upon faith*, and *peace of God is dependant upon prayer*. Dobson *et al.* (2005:1598) explain that peace with God describes the state between God and the Christian, and the peace of God describes the condition within the Christian – the inner peace that is available through *faith* in Jesus Christ (Collins, 1993:126).

Which surpasses all understanding (Philippians 4:7b): This points toward that which surpasses all power of human reason or comprehension (Ephesians 3:20). Lenski (1961:879) concludes that what Paul says is that this is the peace "exceeding all mind" in what it is able to do for one regarding one's heart and one's thoughts. The Christian does not depend on his mind to fend off worry from his heart or thoughts. The peace of God in the Christian will keep peace in the church (Dobson *et al.*, 2005:1598): "You will keep him in perfect peace, whose *mind* is stayed on You: because he trusts in You" (Isaiah 26:3). The Christian can

put everything into God's hand and let the peace of God rule in his *heart* (Colossians 3:15).

Will guard your hearts and minds through Christ Jesus (Philippians 4:7c): It will keep you safely and continually, and the garrison will stand guard as an armed sentinel. The word *guard* actually means "will stand watch over your heart and mind". In other words, *the peace of God will come and occupy the place anxiety once held.* According to Hendriksen (1973:197) God's peace will mount guard at the door of heart and thought.

Foster (1998:194) describes verse 6-7 as being the *result* of always rejoicing, being anxious for nothing and "in everything by prayer and supplication with thanksgiving letting your requests be made known to God". According to Foster (1998:195), the spirit of celebration will not be in one until one has learned to be "careful for nothing". One will never have a carefree indifference to things until one trusts God. When one trusts God, one is free to rely entirely upon him to provide what one needs: "By prayer and supplication with thanksgiving let your requests be made known to God." Foster (1998:195) adds that prayer is the means by which one moves the arm of God; hence one can live in a spirit of carefree celebration.

Significance for depression sufferers

- If people share their concerns with God, God's *peace* will provide emotional strength and result in *joy*.
- *Peace is the product of prayer.* This emphasises the crucial part prayer plays in *healing*.
- Through prayer people place their trust in God. Through prayer people maintain contact and focus on God.

Finally (Philippians 4:8a) means "in conclusion". **Whatever** (v. 4:8b): Dobson *et al.* (2005:1598) remarks that *whatever* introduced six adjectives picturing old-fashioned Christian ideas, namely *true, noble, just, pure, lovely* and *of good report.* **True**: Resting on reality and aiming at reality. **Noble**: Honourable, dignified, worthy of reverence, the combination of gravity and dignity. **Just**: Righteous relations between man and man, and man and God. **Pure**: Stainless, chaste, unsullied. **Lovely**: Lovable, endearing, amiable, gracious, charming, pleasing, winsome. **Of good report**: Attractive, fair speaking. **If there is any virtue** (v. 4:8c): According to Dobson *et al.* (2005:1598), this means *mental,* moral, and physical excellence. **If there is anything praiseworthy** (v. 4:8d) means "anything deemed worthy of praise". **Meditate on these things** (v. 4:8e): Hendriksen (1973:199) argues that nothing that is really worthwhile for believers to ponder and take into consideration is omitted from this summarising phrase. Meditate on them with careful reflection, not casually and superficially, but constantly and logically (Dobson *et al.* 2005:1598): "For as he thinks in his heart, so is he." (Proverbs 23:7). Noble thinking produces noble living; high thinking produces holy living. All these noble qualities were exemplified in Christ and are produced by the Holy Spirit.

The command in verse 8, to think about all the wonderful and lovely things listed here, runs directly opposite to the habits of mind instilled by the modern media (Wright, 2004:131). Read the newspapers: their stock-in-trade is anything that is untrue, unholy, unjust, impure, ugly, of ill repute, vicious and blameworthy. Wright (2004:131) asks if this is a true representation of God's good and beautiful world. How are people going to celebrate the goodness of the creator if they feed their minds only on the places in the world which humans have made ugly? How is one going to take steps to fill one's mind instead with all the things that God has given one to be legitimately pleased with, and to enjoy and celebrate? (Wright, 2004:132).

Foster (1998:195) observes that God has established a created order full of excellent and good things, and it follows naturally that as one gives one's attention to those things, one will be happy. That is God's appointed way to joy. One will not have joy by only praying and singing psalms, one needs to fill one's life with simple good things and constantly thank God for them. Then one will be joyful, that is, full of joy. Foster (1998:195) states that when one determines to dwell on the good and excellent things in life, one will be so full of those things that one will tend to swallow one's problems.

Significance for depression sufferers

- While depression causes pain (negative) thinking, it is also true that negative thinking in turn reinforces the depression.
- People should *focus their minds on truth and the positive things in life*; that is, the fruit of the Spirit. This will avoid negative thinking which in turn will result in joy and peace which is critical for emotional sufferers.

The things which you learned and received and heard and saw in me, these do (Philippians 4:9a): Dobson *et al.* (2005:1598) suggest that Paul was the interpreter of the spiritual life, and his life at Philippi was an illustration of this high and holy thinking. Paul lived what he preached, and he preached by his living (cf. Lenski, 1961:885). His life spoke more eloquently than his lips. The Philippians can safely follow Paul's example and exhortation. He urges them to keep on doing and practicing those things, converting creed into conduct and profession into performance. Hendriksen (1973:200) explains that it is clear that the *thinking* or *meditation* of which the apostle spoke in the preceding passage was not an abstractly theoretical character. It was thinking *with a purpose*, and that purpose lies in the sphere of *action*. According to Wright (2004:132) Paul's command in verse 9 is one of the most demanding ethical commands anywhere in the Bible – not so much for those who receive it, though no doubt it is that as well, but for the person who gives it.

And the God of peace will be with you (v. 4:9b): God will be with His people in this *turbulent*, tempestuous world and bring unity and *harmony* to them and through them to the church (Dobson *et al.* 2005:1598). Wright (2004:132; cf. Hendriksen, 1973:200) reports that as so often, Paul weaves into apparently brief and unconnected strands of thought a theme which turns, teasingly, this way and that. Where does "the peace of God" come from (verse 7)? Why, from "the God of peace", of course (verse 9). Get to know the one and you will have the other.

Significance for depression sufferers

- The promise "and the God of peace will be with you" provides great comfort for depression sufferers.
- Christians should live a *Christ-like life*, using Christ as their role model.
- Christ will share His peace with those who follow and obey His commands.

For Wright (2004:131) the three main things that will come into life if the celebration is both *joyful* and *gentle* are the *prayer* which overcomes *anxiety* (verses 6-7); the patterns of *thought* which *celebrates* God's goodness throughout creation (verse 8); and the style of *life* which embodies the **gospel** (verse 9).

According to Melick (1991:148) the verses 4-9 naturally divide into two major sections (v. 4-7 and v. 8-9), but they unite around the theme of *peace*. In Philippians 4:7 Paul wrote of the *peace of God that sustains Christians during times of hardship*. In Philippians 4:9, he wrote of the result of a proper *thought* life (4:8) – the God of peace will be present (Melick, 1991:148). Anderson and Miller (1999:227; cf. Hart & Weber, 2005:179) agree and indicate that *prayerful meditation* followed by obedience connects people with the peace of God and the God of peace (Philippians 4:6-9). This is a very encouraging word to anyone struggling with fear and anxiety.

Philippians 4:4-7 speaks primarily to those occasions in life when *peace* is lacking (Melick, 1991:148). They are the times when troublesome circumstances interrupt the normal flow of events. Melick (1991:148) states that Paul gave three commands to help the readers solve these problems. In 4:8-9, Paul organised his thoughts to address the need for a peaceful environment. The cultivation of the proper environment brings with it the God who is peace. Melick (1991:148) further explains that some commentators see these commands as applying to the church collectively, rather than to individual Christians, but he states that Paul probably had both individual Christians and the church in mind. Philippians 4:4-7 falls into two sections (Melick, 1991:149). Three imperatives are followed by a promise (indicative) for those who followed Paul's words. Melick (1991:149) shows that the first two commands are emphatic.

3.4.2.2 Rejoicing in Christ's Provisions (Philippians 4:10-13)

But I rejoiced in the Lord greatly (Philippians 4:10a): The Philippians had sent a love offering and Paul's cup of joy overflowed (Dobson, 2005:1598; cf. Lenski, 1961:885). Wright (2004:133) recounts that after what had seemed a long time, as he was in prison in Ephesus with only a few friends and colleagues looking after him, suddenly Epaphroditus had come to town looking for him. He brought news of the church in Philippi; they were facing suffering and various difficulties, but they were firmly loyal to Jesus, and still deeply grateful to Paul for all that he had given them in bringing the **gospel** to them. As a token of it, they were now sending him this gift of money – presumably a quite substantial gift, since it would hardly have been worth while sending a messenger with a small amount (Wright, 2004:133). But Paul rejoiced in the Lord, not their gift (Dobson *et al.* 2005:1598). Lenski (1961:886) states that the connection of "joy" with the Lord is evident when one sees the unselfish, spiritual quality of this joy. "Greatly" is associated with rejoicing and it lets one see how surprised and delighted Paul was when a handsome gift was so unexpectedly presented to him.

Significance for depression sufferers

- All the blessings people receive are gifts from God. People should *thank God* for these blessings and *rejoice in the Lord*.

Your care of me has flourished again (v. 4:10b): Dobson *et al.* (2005:1598) point out that their care not only blossomed again, but it bore fruit (cf. Wright, 2004:133). **Though you surely did care, but you lacked opportunity** (v. 4:10c): Paul travelled far and communication was slow. Dobson *et al.* (2005:1598; cf. Hendriksen, 1973:204) explain that the Philippians did not lack love, but the opportunity to express is. They had not forgotten Paul; they had not failed Paul.

Not that I speak in regard to need (Philippians 4:11a). Paul's commendation was not a complaint in disguise; he was not hinting for another gift (cf. Wright, 2004:133; Hendriksen, 1973:204). Paul does not need gifts to rejoice (Dobson *et al.* 2005:1598). Lenski (1961:888) observe that Paul's joy is without a thought about himself and his personal circumstances. Joy is not dependent on outward circumstances, but on the indwelling Christ. Paul's joy bubbles from within, not from without. **For I have learned** (v. 4:11b): According to Dobson *et al.* 2005:1598), he did not always know this precious truth; he learned it through long, hard experience. **In whatever state I am** (v. 4:11c) means whether he was in prison and in chains; in want and in hunger. **To be content** (v. 4:11d): Self-sufficient, not needing outside help, able to make ends meet. Dobson *et al.* (2005:1598; cf. Hendriksen, 1973:204) argue that Paul was totally independent of man because he was totally dependent upon God. Paul's satisfaction and sufficiency were in Christ (2 Corinthians 12:9).

Significance for depression sufferers

- If people fully depend on God they will experience *inner joy* which comes from Christ. They will experience joy *irrespective of their circumstances*.

I know how to be abased (Philippians 4:12a): Humbled, having very little, and running low as a river in a drought, facing poverty. **And I know how to abound** (v. 4:12b): Overflow in an abundance, having more than enough, facing prosperity. **I have learned both to be full** (v. 4:12c): Well-fed with a seven-course dinner. **And to be hungry** (v. 4:12d): Suffer need. Dobson *et al.* (2005:1599) stress that Paul had been in God's school of discipline, and earned his advance degree by taking post-graduate courses in difficulty. According to Lenski (1961:890) Paul was always in God's hands. If he was to perish from want, it would be God's will. Paul was a victor over every circumstance, not a victim to any circumstance. He adjusted well to the will of God. Wright (2004:133) agrees and states that God has put Paul through a tough school in which he has learned one of the most important lessons of life: *contentment*. According to Hendriksen (1973:205), Paul has learned the secret – he has been thoroughly *initiated* into it by the experiences of life applied to the heart by the Holy Spirit.

Although many other philosophers of the time spoke of contentment (Wright, 2004:134), they usually developed the idea in terms of self-sufficiency. One should find resources within oneself, so that one could smile at the fluctuating fortunes which life threw at one. Paul has a different view: I am strong enough for anything, he says – *because of the one who gives me strength* (verse 13). Wright (2004:134) points out that he leaves it open as to whether "the one" in question means God, or Jesus the **Messiah**, but it seems more likely to Wright (2004:134) that he means God himself – the God that mankind recognise in Jesus.

Significance for depression sufferers

- Paul is content with what he has – even in suffering he is content. No circumstances were too difficult to face since he *lived in the will of God*.
- Depression sufferers can find great comfort in the fact that they can face their agony because God will give them the strength to do so.

I can do all things through Christ which strengthens me (Philippians 4:13): According to Wright (2004:134) Paul often speaks of the energy of power which he found welling up within himself, and which, as he declared, all came from God. He tells the Corinthians that he worked harder than any of the other *apostles*, but insists that it was not him, it was God's *grace* at work in him. He tells the Colossians that he works hard "with all the energy which he inspires within me". There is no doubt that Paul would have struck many people as something of a human dynamo. He achieved more in a comparatively short time – his main public ministry, including the letters, probably lasted not much more than ten years at the most – than most people achieve in a long life. Wright (2004:134) remarks that Paul *suffered* hardships and faced dangers that most people then, and most today, cannot even imagine. However, his testimony in the middle of it all rings down through history to our own day: "I have strength for everything in the one who gives me power." Being connected with the Lord who keeps empowering him, Paul always had the strength for everything in his life and in his work (Lenski, 1961:890). Hendriksen (1973:206) explains that the Lord is for Paul the Fountain of Wisdom, encouragement, and energy, actually infusing strength into him for every need.

Dobson *et al.* (2005:1599) show that Paul has such strength as long as Christ keeps pouring the power (Greek: *dynamis*) into him. According to Louw (2000:181) this power, which enables people to deal with everything through Christ Jesus, is nothing other than the dynamic power that is brought about by the Holy Spirit. A living Christ on the inside is more than sufficient to endure the circumstances on the outside. What Christ wants Paul to do, Christ enables Paul to do. Where the finger of God points, the hand of God provides the way (Dobson *et al.* 2005:1599).

According to Wright (2004:134), as with the previous section about Epaphroditus (Philippians 2:25-30) one here gains a window on Paul as a very human Christian, facing difficulties and troubles, and having to learn the hard way how to

cope with them. There are no instant or easy solutions for him; no casual "leave-it-all-to-God" approach, ignoring the real problems of Christian living and ministry. Instead, he abides by the steady schoolwork God had set him, of finding out the secret of having plenty or having nothing. According to Wright (2004:134), this is the secret, as with everything else for Paul: *the God he knew in Jesus the Messiah enabled him to face everything with a strength that came from outside.* That is a promise for anyone and everyone who is prepared to go to the same school and learn the same lesson (Wright, 2004:135).

Philippians 4:13 is a good text for hard times in the common meaning of the expression and also in its wider meaning (Lenski, 1961:891). Chaffart (s.a.) expresses the opinion that this text is of exceptional help to those struggling with depression. He proposes that depression can be overcome – leave this matter to God and *trust* Him, believing one can be healed "by the stripes of His blood" (1 Peter 2:24). He is *faithful* and will see one through. He will not abandon His children. He promised in Matthew 28:20: "And surely I am with you always, to the very end of the age."

Significance for depression sufferers

- Philippians 4:13 is a very powerful message to all people, particularly those engulfed in life's struggles. God will give people the strength to face all obstacles with joy and thereby live in His peace.
- People can overcome depression through Christ. Sometimes the answers are not simple, but there definitely is *hope*.
- One should *participate* with God. He would not make one's depression go away automatically, but will give one the *strength* to do what He want to do.
- Passive Christians wait around for God to make their depressions go away without participation with God though responsible action – and then they wonder why they remain depressed.

Table 3.3 summarises the megathemes of Philippians (LASB, 2005:1993):

Theme	Explanation	Importance
Christian living	Paul shows people how to live successful Christian lives. One can become mature by being so identified with Christ that his attitude and humility and self-sacrifice becomes one's. Christ is both one's source of power and one's guide.	Developing one's character begins with God's work in one. But growth also requires self-discipline, obedience to God's Word, and concentration on one's part.
Joy	Believers can have profound contentment, serenity, and peace no matter what happens. This joy comes from knowing Christ personally and from depending on his strength rather than one's own.	One can have joy, even in hardship. Joy does not come from outward circumstances but from inward strength. As a Christian, one must not rely on what one has or what one experience to give one joy but on Christ within one.

Table 3.3

In conclusion, if one is to enjoy the power of God at work in one's inner being, then one must model one's relationship on Christ, surround one's circumstances by prayer, drill one's mind in godly thinking, and subject one's life to the Word of God (Motyer, 1991:213).

Prayer is the means to maintain contact with and focus on Christ. One taps into the peace of God through prayer. Peace is the product of prayer. Peace will guard one's heart and mind. It does not mean one will receive everything one asks for, but simply that there will be peace.

Paul's prescription – his antidote to anxiety – can be summarised as follows:

- Attitude: *Rejoice! One can have joy, regardless of circumstances – God is in charge.*
- Action: *In everything – absolutely everything – give thanks and pray.*
- Answer: *Instead of anxiety, one will experience the peace of God.*
- Affirmation: *Think about some new things.*

Next, the **truths revealed from the expositions** of 2 Corinthians 1:3-11, Philippians 4:4-13 (cf. 3.4) and Lamentations (cf. 3.3.4) will be **applied to provide answers for the depression and anxiety of the biblical figures** discussed in 3.3.4. In the same way that these verses offered answers for the biblical figures, it provides comfort and relief for depression sufferers in modern day life.

Table 3.4 summarises the typical characteristics of depression, those characteristics that the biblical figures revealed and the answers offered in 2 Corinthians 1:3-11, Philippians 4:4-13 and Lamentations to those struggling with depression and anxiety.

Summary of the characteristics of depression, characteristics that the biblical figures revealed and the answers offered in 2 Corinthians 1:3-11, Philippians 4:4-13 and Lamentations to those struggling with depression and anxiety

Characteristics of depression (cf. 2.3.4)	Characteristics that Bible figures revealed (cf. 3.3.4)	Answers offered in 2 Corinthians 1:3-11, Philippians 4:4-13 (cf. 3.4) and Lamentations 3:25-28 (cf. 3.3.4)
- Depressed mood. - Decreased interest in life. - Decrease/change in appetite and marked weight loss when not dieting or weight gain. - Suicidal tendencies or recurrent thoughts of death. - Decreased ability to concentrate and indecisiveness. - Decreased energy or fatigue. - Insomnia or hypersomnia.	**Moses** Decreased ability to concentrate; negative thoughts; critical self-talk; anxiety. **Job** Broken; insomnia; thoughts of death. **Elijah** Stopped eating; angry; lonely; tired; suicidal.	**2 Corinthians 1:3-11** - Comfort and consolation comes from God. - Suffering is part of life. - Trust in God, not on oneself. - God listens and responds to prayer. - Pray for one another.

Characteristics of depression (cf. 2.3.4)	Characteristics that Bible figures revealed (cf. 3.3.4)	Answers offered in 2 Corinthians 1:3-11, Philippians 4:4-13 (cf. 3.4) and Lamentations 3:25-28 (cf. 3.3.4)
- Decreased sense of self-worth or well-being and inappropriate or excessive feelings of guilt.	**David** Depressed mood; decreased interest in life; decreased appetite; could not sleep; decreased sense of self-worth or well-being; negative self-talk; hopelessness; sadness; thoughts of death. **Jeremiah** Anger; discouragement; mournful; crying spells; overwhelmed.	**Philippians 4:4-13** - People can experience joy irrespective of their circumstances. - Be gentle with others in their suffering. - Avoid anxiety, it results in negative thinking and immobilises people. - Rather make concerns known to God in prayer. - Thank God for past blessings. - Focus on the fruit of the Spirit – fill mind with positive thoughts. - Imitate Christ – live a Christ-like life.

Characteristics of depression (cf. 2.3.4)	Characteristics that Bible figures revealed (cf. 3.3.4)	Answers offered in 2 Corinthians 1:3-11, Philippians 4:4-13 (cf. 3.4) and Lamentations 3:25-28 (cf. 3.3.4)
		- Keep one's thoughts on God in order to have peace. - Direct one's attention toward one's true source of hope – God. - God will give people strength to face all tribulation. **Lamentations** Understand the true nature of God; He does not intend for people to suffer but provides hope for those that put their faith in Him.

Table 3.4

In conclusion, if people give their anxiety to God, He replaces it with His peace. *Peace with God is dependent upon faith*, and *peace of God is dependant upon prayer.* When people feel anxiety rising, they should turn to God in prayer. Christians can also learn how to handle emotional turmoil by studying the faith-

filled and faith-driven emotional life of Jesus Christ. This is not incorporated in this study but is briefly summarised in Appendix B.

3.5 PRELIMINARY CONCLUSION TO CHAPTER THREE

Chapter three explored the scriptural perspectives and revelation-historical stance regarding *depression* and the healing power of faith. Brief conclusions from this study are summarised below.

Depression is as old as humanity, at least since Adam and Eve were driven from their place of perfect peace. It does not make any difference whether the precipitating cause of depression is physical, mental or spiritual. Depression and anxiety affects the *whole* person, and a complete cure requires a *holistic* answer. No human problem manifesting in one dimension of reality can be isolated from the rest of reality. Depression is related to a person's *physical health*, what they *believe*, how they *perceive* themselves, their *relationship with God*, their *relationship with others*, the *circumstances* of life, and finally, it may have something to do with *Satan*, who is the god of this world. One cannot successfully treat depression without taking into account all related factors. That is God's way of caring for people. *Faith* involves a kind of positive thinking that by itself *heals* and prepares the body for *healing* Anxiety is most of the time overcome by *faith* in God, and *spiritual attacks* are overcome by worshipping God in one's daily life. Faith is actually a source of comfort and consolation, provided that it is active and alive (cf. 3.2).

The Bible does not use the words *mood* and *anxiety disorder* or *depression*, although it describes people whom might be suffering from it. Great men of God have been known to suffer "depression". The Bible tells of kings and prophets who became depressed. King David, Moses, Job, Elijah and Jeremiah are good examples. They frequently developed health issues and expressed anger with

God. Yet, God spoke to them, like many other biblical figures, not because they had special abilities, but because they were willing to listen to Him (cf. 3.3.1).

Both psychology and the Scriptures point to the fact that anxiety can be either normal or abnormal. Anxiety may be the antithesis of faith. Considering the fact that God created man and gave people emotions, it can be concluded that sin is the cause of unhealthy or out of control emotions. The effect of sin must be dealt with in order for *healing* to occur (cf. 3.3.1).

The word that is commonly translated *faith* in the Bible means more than mere *belief*. It also implies dependence and trust. Faith, because it incorporates dependence and trust, also embodies *action*. This action can take many forms, but belief that does not eventuate in a changed life is not true biblical faith. Faith is *living, it moves and it can be perceived*, because true faith trusts and depends on God. Faith sees God as He is. Faith believes what God can do. Faith anticipates what God will do. Faith believes God has the power. Faith is *belief based on facts*. But faith is more than recognition of facts. A person may know all about Christ as revealed in the Bible, may even believe God's Word to be true, and yet not have real faith in Christ as his personal saviour. Agreement by the mind is not the same as surrender of the heart. Faith needs strengthening, because it constantly faces attacks by one's sinful nature and the entire evil world, which contradict it. The Lord strengthens faith in different ways (for example through testing and his guidance of one's entire life). God uses temptation to test *faith*. Not that God tempts people, for God is not the author of evil, but He allows Satan to do so. From the above it can be concluded that *faith* is not only essential for salvation; it is the anchor for the soul (cf. 3.3.2).

The Bible is full of accounts of *healing*; particularly the Gospels. Jesus, Paul, and the rest of the early church lived in regular expectation that God would heal people's physical bodies. According to all four canonical Gospels, Jesus Christ devoted a considerable part of his ministry to performing *miracles* of *healing* for a

CHAPTER FOUR

BASIS-THEORETICAL PERSPECTIVES ON THE HEALING POWER OF FAITH IN MOOD AND ANXIETY DISORDERS: "POPULAR THEOLOGICAL APPROACHES"

4.1 OBJECTIVES

The objective of this chapter is to study *popular theological perspectives* on the healing power of faith in mood and anxiety disorders. As mentioned in chapter three, the basis-theoretical perspectives on *the healing power of faith in mood and anxiety disorders* can be divided into two groups, namely the *expository perspectives*, and a separate division that concentrates on the *popular theological literature*. The latter will be studied in this chapter. When reference is made to *popular theology*, it refers to a specific *genre* in theological literature that endeavours to convey biblical norms and values in such a way that the layman can understand and apply these norms and values to his or her life (Schoeman, 2005:94).

4.2 INTRODUCTION

Through the years, the scientific studies linking the emotions and disease have produced an impressive body of research, all of which points to the conclusion that *what* one feels as emotions results in *how* one feels physically (Colbert, 2003:9). There is a growing body of research evidence suggesting that deeply religious people are significantly happier about their lives and recover faster from illness than people who do not share as strong a faith. However, people have separated church and state, medicine and spirituality, healing and faith, etc. Turo-Shields (s.a.) postulates that it is hurting people to live this way and that it is time to reclaim interdependence and begin living holistically again. Christians are

disrespected and often under attack. Most never talk about their Christian beliefs in public, for fear of reprisal.

According to Hart and Weber (2005:162) stress, *anxiety*, and related *depression* are now considered epidemic and the leading mental health disorder. The affective disorder that psychiatrists and psychologists call *depression* is characterised by a feeling that one's *emotional* state is no longer under one's control (Bear *et al.*, 2001:686; cf. Faw, 2004:148; 1.2.1; 2.2). Faw (2004:148) states that severe forms of depression represent one common type of mood disorder and may be associated with self-destructive *thoughts* or suicide attempts (cf. 2.6; 2.7).

According to the National Institute of Anxiety and Stress (2005), one in every eight Americans aged 18-54 suffers from an anxiety disorder. This totals over 19 million people. Anxiety disorders are the most common emotional struggles of today, affecting 20-30 million people (ADAA, 2006; cf. SCB, 2001:1568).

Minirth and Meier (2002:169) point out that Luke 8:14 lists three obstacles that choke individuals after they hear the Word of God. Two of these (the pleasures of this life and riches) most have heard about whilst growing up, but not many heard about the third (care or *anxieties*). Anxieties truly choke many people, and yet all people experience some anxiety at times. Anxiety also often accompanies depression (ADAA, 2006; Minirth & Meier, 2002:169). Anxiety keeps a person from relaxing and from resting. It is a pervasive, long-term inner feeling of nervousness, unrest, and uneasiness.

Anxiety's symptoms can include tense feelings; feelings of apprehension, dread, concern, restlessness and worry; rapid heartbeat; shortness of breath; chest pains; dry mouth; increased blood pressure; jumpiness or feeling faint; excessive perspiring; feeling clammy; numbness; tingling in hands and feet and anticipation of trouble; misfortune; danger or doom (SCB, 2001:1568; cf. Anderson & Miller,

1999:12, Minirth & Meier, 2002:169). According to Meyer (2002:119), *anxiety* and worry are both attacks on the *mind* intended to distract people from serving the Lord. The enemy also uses both of these torments to press people's *faith* down, so it cannot rise up and help them live in victory.

Depression is a condition in which a person feels extreme sadness, withdraws socially, feels guilty and expresses self-deprecating thoughts (Uys & Middleton, 2004:319; cf. Fowler, 1999). *Depression* occurs so frequently in the general population that it has been called the "common cold of emotional disorders" (Solomon, 1998; cf. 2.2). Coe (2004:40) proposes that one must live by faith, and faith is far more than feelings.

Burkett (1998:122) has found that whereas mental suffering revolves around one's attitudes and thought patterns, emotional suffering reflects the pain one experience in one's feelings. Faw (2004:171) and Horowitz (2002:3) also agree that health must be addressed holistically – physically, mentally, emotionally, socially, environmentally, and above all *spiritually* (cf. Solomon, 1998; Burkett, 1998:122). Collins (1993:234; cf. Bruno, xvii) observes that a Christian cannot conceive of *true spirituality* without the guidance of the Holy Spirit of God and the truth of the Word of God. Christian spirituality is a process of becoming increasingly Christ-like (2 Corinthians 5:17) and holiness is at the essence thereof (Collins, 1993:234). Koenig (2005:286) defines *spirituality* as the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationships to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community.

Rather than pursue the ever popular, increasingly vague term *spirituality*, many pastoral clinicians now follow the convention of speaking of *faith*. Whitaker (1995) explains that faith has far more developmental, primal, limbic roots that are nurtured or arrested in the course of a person's life. According to Hamer (2005:11)

faith is hardwired into a person's genes. The components of the limbic-brain stem system communicate with one another in a different way (Hamer, 2005:100). The network looks like a fan rather than a mesh, with its base located in a limited number of cell groups (called nuclei) in the brain stem and hypothalamus. Hamer (2005:101) comes to the conclusion that the type of information conveyed is about values, not sights or sounds – whether something *feels* good or *feels* bad, and not whether it is red or green. The limbic-brain stem system is about *emotions*, not about scenes. Faith in this context is the product of the life process through which one makes moral and existential meaning. It is from this meaning-making process that one finds hope. Whitaker (1995) indicates that hope, along with faith and love, are valuable, sacred commodities in the lives of those who struggle to preserve *mental health*.

The list of kinds of *faith healing* is extensive. Hamer (2005:146) asks the question "Does faith healing actually work?", and reports that there is no systematically collected data available on this issue, but points out that enough people believe that it works to warrant scientific investigation. Faw (2004:171), however, states that while faith in God may enhance mental health, this is not the experience of all believers. For a variety of reasons, faith and emotional health are often not linked closely. God cares for the *whole* person, but His first concern is one's growth in likeness to Christ (Faw, 2004:171).

According to Koenig (1999:299), *healing* can include dramatic, sudden physical cures, but is not confined to the "miraculous" or the spectacular. Perhaps for most people, the *healing power of faith* involves a healing of the mind and emotions, of the tangible spirit, and of relationships with others (see 4.4).

In the end, achieving *inner peace* may or may not result in physical healing; but even if the physical is not healed, it is very likely the burden of illness will be lighter. Koenig (1999:299) observes that such healings may be sudden, or they can take time – often months, and sometimes years. *Faith* often involves

persistence and patience. Coe (2004:40) indicates that *faith* is *belief* (cf. Hebrews 11:1; 3.3.2) – founded in fact, encouraged by the Spirit, and shown through action. *Faith* is confidence that one will receive what one desires before one actually has it. *Faith* involves a kind of positive thinking that by itself *heals* and prepares the body for *healing*. Most of the angst and suffering that people experience is not a result of physical pain, but of outlook, emotions, and relationships with others. Koenig (1999:299) also argues that *healing* in these areas can put physical health problems in true perspective, prevent them from dominating a person's life, liberate one from stress and *depression*, and free the body to *heal* itself.

These issues will be discussed in this chapter with specific reference to popular theological perspectives on mood and anxiety disorders (4.3), on faith (4.4) and on healing (4.5).

4.3 "POPULAR THEOLOGICAL" PERSPECTIVES ON MOOD AND ANXIETY DISORDERS

After many years of denial and misunderstanding, Christians are coming to recognise that *depression*, *bipolar disorders* and *anxiety disorders* are complex psychopathological conditions (Tan & Lyles, 2005:158). They can be effectively treated, but they are not likely to be dismissed by simplistic explanations or approaches to treatment.

Christians are not exempt to depression and anxiety (Tan & Ortberg, 2004:10; cf. Brits, 2004b:57; Anderson *et al.* 2000:9; Seamands & Funk, 1992:151). Although one will occasionally find churches or religious leaders who argue that firm spiritual commitment should be a safeguard against depression, studies have generally not found significant differences between "religious" and "nonreligious" groups in terms of their vulnerability to depression. Tan and Ortberg (2004:20) remark that psychologist Dr. Archibald Hart estimates that in a typical church at

least 5% of the congregation will be experiencing significant depression at any given time. Koenig (2004:38) agrees that deeply religious people can also experience depression and anxiety.

Depression has a spiral quality to it, as if it were feeding on itself. Many depressed people feel *guilty* about the fact that they are depressed (cf. Burkett, 1998:123). Tan and Ortberg (2004:16; cf. Prinsloo, 1998:81)suggest that this is often true of Christians, who sometimes feel that their depression is an indication of a lack of *faith*, and that if they simply had as much *faith* as a "normal" Christian they would not be depressed. Of course, such guilt, instead of motivating and empowering change, only serves to make the depressed person that much more depressed (Tan & Ortberg, 2004:16; cf. Koenig, 2005:90). Seamands and Funk (1992:153) maintain that by denying their depression, many Christians add to their troubles, in the sense that they add *guilt* on top of the depression and thereby double the problem.

Meier, Minirth *et al.* (1997:280) have found that a precipitating cause of depression in many Christians is a *wrong perspective*. In an affluent society with many temptations, it is easy to develop the *wrong focus*. Anderson and Miller (1999:66) agree and show that the minds of those struggling with anxiety disorders are riddled with contaminated thinking and erroneous thoughts about themselves, God, and their circumstances of life. Connecting with God through genuine repentance and renewing of one's mind to the truth of His Word will help one to fill one's mind with positive and constructive thoughts which is essential for the healing of damaged emotions (cf. Brits, 2004b:81; Philippians 4:7; see 3.4.2).

Anderson *et al.* (2000:111) note that from a Christian perspective, *cognitive-behavioural therapy* is a valuable part of the *repentance process*, as long as it is biblically based. Repentance begins by admitting one was wrong; that what one believed was not true. One cognitively makes that choice, and one chooses to believe the truth according to God's Word and live accordingly from this day on.

Anderson *et al.* (2000:111) also point out that in a secular clinical setting, the outcome typically involves realising one's error in thinking and disputing it; in a Christian clinical setting, however, it is crucial to remember that God grants repentance, and the Holy Spirit guides a client into all truth. Renewing one's mind is essential for sanctification, and the truth will set one free (cf. 3.3.2).

Solomon (1998) is of the opinion that the person who is depressed should be treated as a *whole* person (cf. 2.2). He quotes John White, a practicing Christian psychiatrist and author of the book entitled *The Masks of Melancholy*: "I will no more treat mind as distinct from body than body as distinct from mind. By the grace of God I will treat persons, not pathology, sinners rather than syndromes, and individuals rather than illnesses. And however primitive our weapons may be, there are effective weapons and we must use them."

Unfortunately, just like with Job (cf. 3.3.4) when he was struggling with depression, some of one's Christian friends can be one's worst enemies at this point, offering false and unrealistic advice (Seamands & Funk, 1992:154; cf. Burkett, 1998:123). The difficulty is the way the church, in general, condemns or makes the battle against depression a moral issue (Burkett, 1998:123; cf. Brits, 2004b:68). Burkett (1998:123) indicates that depression, which is often the way emotional suffering is manifested, may or may not have moral or spiritual roots to it. Most people who battle some type of physical illness know how hard it is to battle depression. If someone experiences mood swings, depression, or prolonged emotional suffering of some sort, few would recommend medication as part of that person's solution. Burkett (1998:123) warns that it is too easy to say, "Well, you just need to pray more," or "You *must* have some hidden, *unconfessed* sin *somewhere* in your life." Such comments usually provoke more guilt, shame, or inadequacy, which only exacerbates the problem, leaving the person in an even deeper tailspin (cf. Tan & Ortberg, 2004:16). Heaping on more guilt does not constitute a blessing to someone struggling with emotional pain.

Seamands and Funk (1992:154) agree that there are Christians who have little understanding about depression. Because their own personalities are not very subject to it, they fail to understand people who suffer depression. This can be especially cruel when two such people are married to each other (Seamands & Funk, 1992:154). If a husband for example does not suffer much from depression but the wife does, he may have a difficult time appreciating her emotions and her moods. It can be a doubly cruel situation if he uses her depressed time to put a spiritual burden on her. The same is true for the wife if the situation is reversed. One cannot assume that because one never suffers from depression, one is therefore more spiritual. According to Seamands and Funk (1992:154), C.S. Lewis once remarked that about half the times when one credits oneself with virtue, it is really just a matter of temperament and constitution, and not of spirituality.

According to Minirth and Meier (2002:170), *anxiety* is the underlying cause of most psychiatric problems. It is the cause of neuroses, psychoses, and psychophysiologic disorders. It can be the cause of phobias. It can be the real underlying problem in people who think they have committed the unpardonable sin (cf. 3.3.3). According to Burkett (1998:122), in today's culture, many equate emotional struggles with spiritual weakness or even mental disturbances. As in the case with physical illness, it's always a possibility that emotional struggles can be rooted in some issues of sin, but it is too simplistic – and just plain wrong – to say that it is always the case.

Both psychology and the Scriptures point to the fact that anxiety can be either normal or abnormal (Minirth and Meier, 2002:170). Psychologists have long noted that individuals are more efficient and productive when they have some kind of anxiety. However, if the anxiety becomes intense, their efficiency begins to decrease accordingly. The Scriptures also indicate that some anxiety (a realistic concern as seen in verses like 1 Corinthians 12:25; 2 Corinthians 11:28; Philippians 2:20) is healthy. However, intense anxiety (fretting and worrying, as

seen in Luke 8:14; Philippians 4:6; 1 Peter 5:7) is not healthy. Minirth and Meier (2002:170) explain that the Greek word (*merimna*) often translated *anxiety* is used about twenty-five times in the New Testament. It is normally used in the negative sense (implying worrying or fretting), but occasionally in a positive sense (a realistic concern). Technically, *anxiety* is secondary to unconscious conflicts, while *fear* is secondary to conscious conflicts. However, practically speaking, the two often cannot be separated (Minirth and Meier, 2002:170). There are approximately 350 passages in the Bible that tell us not to "fear".

Emotional pain and suffering are very real, and rather than helping people see God as their merciful father, eternally filled with compassion and care, often people's responses simply drive people further away from God by heaping on guilt and shame (Burkett, 1998:123). Nevertheless, the Scriptures indicate that God desires for one to draw near to Him in one's time of need: *"The righteous cry and the Lord hears, and delivers them out of all their troubles. The Lord is near to the broken-hearted, and saves those who are crushed in spirit"* (Psalm 34:17-18). God is *merciful*. He cares about the pain and suffering one is experiencing, whether it is physical, mental, emotional, or spiritual. Burkett (1998:129) urges that one should trust Him and He will give one peace – not escape – *peace*. Bad things happen to good people, and wonderful, godly people experience tragedy (as was the case with Job), but for the believer there is peace (Trask & Goodall, 2000:59). The Bible never promises that one will escape the storms of life; it does however, promise one peace and protection in the midst of those storms.

According to Horowitz (2002:15), body sensations, *emotions*, and *feelings* should also be understood for their primary *spiritual* function. God created people, like every other natural creation, according to a *cybernetic system* in keeping with His natural laws of balance and judgement. Cybernetics is defined in the *Webster's Online Dictionary* (2006) as "a system of feedback and communication in all living and nonliving systems". Horowitz (2002:16) adds that as a Holy child of God, one was also designed with cybernetic feedback and communication systems. The

principle function of emotions is feelings, as the principle function of the body is sensations. God gave one these so that when one makes choices and takes actions, one's body sensations, emotions and feelings give one (often immediate) internal feedback as to whether or not one is acting in keeping with His laws, values, and goals for one. These feedback circuits inform one whether or not one is on the right track to achieve, or maintain, one's positive health values, goals and blessings.

The Bible does not use the words *mood* and *anxiety disorder* or *depression*, although it describes people whom might be suffering from it. Taylor (1999; cf. Solomon, 1998; Brits, 2004b:30) states that there are numerous biblical references to "depression", one of the most common and distressing afflictions of human beings. He remarks that it is likely that the first humans to experience depression were Adam and Eve, after they sinned against God. Solomon (1998) also points out that at one point in his life, Moses wanted to die (Exodus 32:32).

The prophecy of Isaiah 53:3 states that the Suffering Servant, the Lord Jesus, was "a man of sorrows, and acquainted with grief". According to Solomon (1998) *sorrows* and *grief* can refer both to physical and *mental* pain, which could include *depression*. Examples of people in the Bible who suffered bouts of possible depression and Scripture references where one reads about it (cf. Taylor, 1999):

- Abraham – Genesis 15.
- Jonah – Jonah 4.
- Job – Book of Job.
- Elijah – 1 Kings 19.
- King Saul – 1 Samuel 16:14-23.
- Jeremiah – Book of Jeremiah.
- David – As described in Psalms 6, 13, 18, 23, 25, 27, 30, 31, 32, 34, 37-40, 42-43, 46, 51, 55, 62-63, 69, 71, 73, 77, 84, 86, 90-91, 94-95, 103-104, 107, 110, 116, 118, 121, 123-124, 130, 138, 139, 141-143, 146-147.

4.4 "POPULAR THEOLOGICAL" PERSPECTIVES ON FAITH

The King James Version of the Bible defines *faith* in Hebrews 11:1 as "the *substance* of things hoped for, the *evidence* of things not seen" and the New American Standard Bible says in the same verse, "Now faith is the *assurance* of things hoped for, the *conviction* of things not seen". Faith is learning to depend absolutely on God and His Word, regardless of one's circumstances; meaning that one's faith will remain firm because it is focused on and fastened to a living God (McDonald, 2004:29). "We have this hope as an anchor for the soul, firm and secure." (Hebrews 6:19). Instead of allowing one's fear to take over when life feels "out of control", one is asked to take a step of faith and "cast all your anxieties on the Lord because He cares for you" (1 Peter 5:7).

Faith is a spiritual muscle that needs to be exercised in order to prevent atrophy, which makes one's entire spiritual being weak (Omartian, 1991:126). Faith is first a decision, then an exercise in obedience, then a gift from God as it is multiplied. One's first step of faith is taken when one decide to receive Jesus Christ. After that, every time one decides to trust the Lord for anything, one builds that faith.

Coe (2004:113) indicates that since faith always shows itself in action and since one cannot always see the object of one's faith, there is an important conclusion to be drawn from this verse: sometimes faith means moving forward when one cannot see what is up ahead. Faith is the supreme requirement for "heaven's favour" (Benson 2003:30). McDonald (2004:30) suggests that most people understand that there is *saving faith* that is real and other claims to "saving faith" that are not genuine. According to Faw (2004:125) it is clear that saving faith is a gift from God (Ephesians 2:8) that does not rest on human understanding alone. Faith involves a commitment to Christ and a growing relationship with Him, aspects that clearly go beyond the cognitive domain. The biblical injunction to "become as little children" (Matthew 18:3) suggests that faith is not closely tied to

cognitive capacity (Faw, 2004:125). Faith is related to, but not synonymous with cognition (Faw, 2004:125).

Genuine salvation through faith requires putting one's faith and trust completely in Christ (MacDonald, 2004:30; cf. De Bruyn, 1997:172). Among genuine believers, there can be different types of faith. According to McDonald (2004:30) a person who does not trust God in all areas of his life is a person of "little faith". In Scripture one finds Jesus Christ talking about the "little faith" or lack of faith of the disciples written about in nine different places (although some of these accounts are repeats by the writers of the four Gospels). McDonald (2004:30) stresses that one needs to understand that Jesus Christ was not talking about the *size* of the disciples' faith, He was talking about the *immaturity* and *incompleteness* of their faith. The faith that sees the *invisible*, hears the *inaudible*, and believes the *unthinkable* is the type of faith Abraham and Job displayed (McDonald, 2004:30).

According to Fields (s.a.), there are two types of faith. One faith produces works and is fruitful while the other is barren (James 2:14-26). A faith that does not produce fruit, is not a *saving faith* (James. 2:14). Fields (s.a.) also remarks that a true knowledge of God *will* produce fruit (2 Peter 1:2-4) and therefore one must conclude that this faith which does not save is not true knowledge of God, but rather a bare outline, or a shadow form of the truth (Romans 2:20) which is available to all mankind (Romans 1:19).

Christianet (2004) gives the following summarising notes on faith:

Faith in Christ is:

1. Precious – 2 Peter 1:1.
2. One's author and finisher – Hebrews 12:2.
3. The Gift of God – Romans12:3; Ephesians 2:8; 6:23; Philippians 1:29.

Through faith in Christ one has:

1. Salvation – Mark 16:16; Acts 16:31.
2. Eternal life – John 3:15,16; John 6:40,47.
3. Sanctification – Acts 15:9; 26:18.
4. Justification – Acts 13:39; Romans 5:1; Galatians 2:16.
5. Edification – 1 Timothy 1:4; Jude 1:20,21.
6. Access to God – Romans 5:2; Ephesians 3:12.
7. Rest in heaven – Hebrews 4:3.

Faith produces:

1. Joy – Acts 16:34; 1 Peter 1:8.
2. Hope – Romans 5:2.
3. Peace – Romans 15:13.
4. Confidence – Isaiah 28:16; 1 Peter 2:6.

Faith is exemplified in:

1. Caleb – Numbers 13:30.
2. Shadrach, Meshach & Abednego – Daniel 3:16,17.
3. Daniel – Daniel 6:10,23.
4. Ethiopian – Acts 8:37.
5. Philippian jailor – Acts 16:31,34.
6. Enoch – Hebrews 11:5.
7. Noah – Hebrews 11:7.
8. Abraham – Hebrews 11:8,17.
9. Rahab – Hebrews 11:31.

Omartian (1991:127) lists the following characteristics of faith:

- Faith is a choice.
- Faith is a step of obedience.
- Faith is a spiritual exercise .

- Faith is taking God at His Word.
- Faith is saying yes to God.
- Faith is looking to Jesus Christ for everything.
- Faith is knowing one is never without hope.
- Faith is what lifts one out of one's circumstances.
- Faith is not holding anything back from God.
- Faith is being obedient even if one does not feel like it.
- Faith is a gift from God as one reads His Word.
- Faith is knowing that everything will work out.
- Faith is a way out of one's limitations.
- Faith is the mother of hope.
- Faith is the road to peace.

A growing body of scientific evidence is beginning to suggest that *religious faith* – as measured by intensity and sincerity of belief, frequency of prayer, congregational membership and attendance at services – can actually shield people from illness (Koenig, 2003; cf. UC, 2005). According to Koenig (2005:280), *faith*, as used here, involves religious belief and commitment to those beliefs. Although more research is needed, the findings show a potential association between *religion*, *spirituality* and *health*. Koenig (2003) gives the following findings from various studies:

- *Faith and life satisfaction*

  As *baby boomers* enter middle age, millions seek meaning in their lives that secular accomplishment cannot provide. People with religious faith tend to enjoy higher levels of life satisfaction, the foundation for psychological well-being, which itself may influence general health.

- *Faith and family stability*

  Couples sharing a faith divorce less frequently than those without a mutual religion. People of strong faith are more apt to protect their marriages as sacred, to seek pastoral counselling and to modify behaviour to prevent divorce. Because the devastating psychological effect of divorce – with its attendant physical-health risks – is well established, religion's possible role in protecting marriages becomes an important public-health factor.

- *Religious people have healthy lifestyles*

  Smoking and the abuse of alcohol and illegal drugs are contemporary plagues. Adolescents and adults from strong religious backgrounds are far less likely to drink, smoke tobacco, experiment with illegal drugs, or acquire sexually transmitted disease than the less religiously active.

- *Religion, coping and depression*

  Religious people cope better with major stress involving health problems or loss of loved ones compared to those who lack the comfort of faith or the emotional support of a congregation. Further, people who regularly attend worship services are significantly less likely to become depressed, and those with deep intrinsic religious faith have been shown to recover from depression more quickly.

- *Religious people live longer, healthier lives*

  There also appears to be a connection between congregational membership and worship, better physical health and improved longevity.

According to Murray and Fortinbury (2004:27), people are *neurologically* geared for *spirituality*. They believe, and many researchers confirm, that without a solid grounding in spirituality there can be no happiness. Even if people are filled with doubt, anger, or *despair* they can discover their own functional spirituality.

However, spirituality does not necessarily imply belief (Murray & Fortinbury, 2004:27). It is a feeling of being able to commune with, or even to rely on, something greater than oneself. An ability to lose oneself in that greater Is. Sometimes spirituality takes the form of surrender and letting go, and at others, it becomes a powerful incentive to action. Koenig (2005:286) defines *spirituality* as the personal quest for understanding answers to ultimate questions about life, meaning, and relationships to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community. Nevertheless, whatever aspect it takes for the individual, spirituality, like a sense of purpose, is a powerful weapon against *depression* and pessimism (Murray & Fortinbury, 2004:27).

The author agrees with Koenig (1999:296), who points out that it takes both deep personal faith in God and an active involvement in a faith community for people to obtain maximum health benefits. If people include religion in their lives from a sincere sense of faith, better mental and physical health may naturally follow. Horowitz (2002:169) expresses the opinion that developing faith in God is the first provision necessary to experience miraculous healing and to be blessed beyond measure.

Hart and Weber (2005:179) report that scientific research is now validating the power of *prayer* in healing and recovery. The discipline of Christian meditation on Christ and His Word is an important heritage since the first days of the Church, but misunderstood and distorted by new age and eastern religions (Hart & Weber, 2005:179; cf. Foster, 1998:20). According to Meyer (2002:178), meditating (pondering, thinking about) the Word of God in one's mind will actually affect one's physical body. According to Hart and Weber (2005:179), the benefits of the power of prayer and meditation are more profound than the calming effect on the body, mind and emotions, like the healing infusion of hope and encouragement that builds *faith* knowing others are praying for one. The ultimate transformation comes as one comes into *relationship* with the healing God who sets people free

from the wounds and strongholds of the past, bringing reconciliation with Himself, oneself and others (cf. Foster, 1998:17).

Hart and Weber (2005:174) propose that *spirituality* is important for complete healing. In addition to counselling and medication, the *healing power* of *a* relationship with God, the Bible, prayer and connection with others are essential. Peace of mind, tranquillity, hope and unconditional love can be viewed as the ultimate remedy for *fear*, *worry*, and *anxiety* (Hart & Weber, 2005:174). According to Meyer (2002:119) peace is not something that can be put on a person; it is the fruit of the Spirit (Galatians 5:22), and the fruit is the result of abiding in the vine.

Many forces in society prevent one from having truly empowering spirituality (Murray & Fortinbury, 2004:27; cf. Bruno, 2000:xvii). Controlling cults or religions; fear of ridicule by colleagues, friends, or family; a pervasive sense that science and spirituality are enemies (which is simply not true); and in some cases government that support a particular form of belief to the exclusion of others interfere with people's attainment of true spirituality (Murray & Fortinbury, 2004:28). The all-pervasive materialism of the economic system is the largest obstacle people have to face. Murray and Fortinbury (2004:28) indicate that even if one is filled with doubt, anger, or despair one can discover one's own functional spirituality.

Bruno (2000:xviii) considers modern society as naïve to think it can address deep-rooted problems that plague people without a spiritual base. He refers to Jung, who said that every psychological problem is ultimately a matter of *religion*. One's spiritual health is absolutely necessary for one to have psychological health. At the same time one cares for oneself spiritually, one needs to not neglect one's psychological health. Spirituality is not a substitute for what one needs to do psychologically in one's life (Bruno, 2000:xviii). One needs to build a bridge between spirituality and psychology, and weave both into the fabric of one's lives.

Jesus Christ did not identify or divide His truths into different categories (Bruno, 2000:xviii). Bruno (2000:xviii) uses the metaphor of one's life being a brightly painted chariot, pulled by two equally strong, beautiful white horses. Their names are "psyche" and "spirit." Together, running side by side, they pull one's chariot of life. When one is out of stride, it affects the other, and one's chariot falters. Neither horse is meant to outrun or overpower the other. Balance is the key. Bruno (2000:xix) believes that a new model is needed that has room for both psychology and spirituality. A *holistic* model is needed that addresses the needs of a *whole* person.

According to Myers (2000:59; cf. Joubert, 2005:161) *faith* connects to psychological science not only by motivating scientific inquiry and sensitising one to implicit values, but in other ways, as indicated in table 4.1, as well. He states:

> *We can, for example, make religion a dependent variable by studying the psychology of religion. (Why do some people take the leap of faith, while others do not?) We can make religion an independent variable by asking whether it predicts attitudes and behaviours. (Are people of faith noticeably more or less prejudiced? generous? happy?) And we can ask how insights into human nature gleaned from psychological research correspond to biblical and theological understandings: as when boring a tunnel from two directions, the excitement comes in discovering how close the two approaches are to connecting.*

The following table explains seven ways in which *faith* relates to *psychology*:

Seven ways in which *faith* relates to *psychology* (Myers, 2000:59; cf. Joubert, 2005:161)

Integration strategy	Personal examples
1. *Faith motivates science*. Believing that *in everything one deals with God* (Calvin), and aiming to worship God with one's mind, one can rigorously search God's world, seeking to discern its truths, while recognising the limits of science.	1. Experiments on *group polarisation* (exploring how group discussion changes and strengthens attitudes). 2. Reviewing studies of subjective well-being (who is happy?).
2. *Faith mandates sceptical scrutiny*. In the ever-reforming spirit of humility, one puts testable claims to the test. This is the empiricism advocated by Moses: "If a prophet speaks in the name of the Lord but the thing does not take place or prove true, it is a word that the Lord has not spoken" (Deuteronomy 18:22).	1. Scrutinising claims of the efficacy of intercessory prayer and faith healing. 2. Reporting tests of New Age claims of reincarnation, channelling, fortune-telling, aura readings, telepathy, clairvoyance, astrology (and their implications of human godlike powers).
3. *Being true to one's deepest convictions and values*. Like everyone, one infuse certain assumptions and values into one's teaching, writing, research, and practice.	Writings for Christian and secular audiences (e.g., Myers, 1998, 1999; Myers & Jeeves, 1987).
4. *Giving psychology to the church*. One can also *apply* psychology's insights to the church's life. For some, this means merging Christian and psychological insights pertinent to counselling and clinical practice.	Showing how social influence and memory principles might be applied in creating memorable, persuasive sermons and undertaking effective evangelism.

Integration strategy	Personal examples
5. *Relating psychological and religious descriptions of human nature.* One can map human nature from two directions, asking how well psychological and biblical understandings correlate.	Relating psychological research (in biological, developmental, cognitive, and social psychology) to the Christian.
6. *Studying determinants of religious experience.* The psychology of religion can explore influences on spirituality, religious commitment, charismatic behaviour, etc. Who believes – and why?	Exploring parallels between (a) research on the interplay between attitudes and behaviour, and (b) biblical-theological thinking about the interplay between faith and action.
7. *Studying religion's effects.* Is faith a *predictor* of people's attitudes?, emotions?, behaviour?	Summarising links between faith and joy (religious commitment and self-reported life satisfaction and happiness.

Table 4.1

4.5 "POPULAR THEOLOGICAL" PERSPECTIVES ON HEALING

Horowitz (2002:139) observes that contrary to popular belief, God wants people healed, living among healthy people, and enjoying a peaceful planet. There is no doubt for the Christian that God can heal, and hopefully there is no doubt that He can still do this today (Anon, 2001a; cf. Blomberg, 1992:306). Brits (2004b:79) stresses that all healing comes from God, while Ellel Ministries (2005) state that doctors recognise that one's physical health and general well-being are greatly affected by one's emotional condition, one's thinking and one's personal relationships. The physical, emotional, and spiritual are linked in ways people are only beginning to explore and understand.

Faw (2004:169) argues that although one must not equate the notions of mental health and spiritual maturity, it is clear that they are often linked. The fact that good emotional adjustment can be nurtured by Christian faith is evident when one reflects on the three ingredients of mental health identified by Grounds (1976) and quoted by Faw (2004:169):

- *Meaning* – a deep conviction that life has meaning. Without this there will be little motivation or purpose for day-to-day activities.
- *Courage* – courage to face the many challenges that life brings. Though one is occasionally fearful and terrified with what lies ahead, it is clearly unhealthy to feel constantly overwhelmed by what one faces.
- *Love* – one must be able to both give and receive love. This implies the presence of stable, meaningful, and satisfying relationships.

More specifically, according to Faw (2004:169), faith in God and a sense of his calling on one's life can provide meaning and purpose. In addition, the security of belonging to God and being indwelt by his Spirit is an excellent antidote to fear and timidity (1 Timothy 1:7). According to Koenig (1999:299) *healing* can include dramatic, sudden physical cures, but is not confined to the "miraculous" or the spectacular. For most people the *healing power of faith* involves a healing of the mind and emotions, of the intangible spirit, and of relationships with others. Achieving this type of *inner peace* may not result in physical healing; but even if the physical is not healed, it is very likely the burden of illness will be lighter. Such healings may be sudden, or they can take time – often months and sometimes years (see 3.2).

Depression has major *physical health* consequences (Koenig, 1999:132). Severe depression stemming from physical illness can exacerbate the disease and even provoke premature death. Chronic, unmitigated depression may itself be the root cause of many life-threatening diseases. However, the good news, according to Koenig (1999:132), is that people who enjoy religious faith appear better able to

endure life's unavoidable hardships with what we aptly call "grace under pressure". They suffer depression like any other person, but they usually rebound quickly because their faith protects them from an emotionally wrenching sense of permanent isolation.

Jesus Christ, who was fully human and therefore fully understands people, shows in His healing ministry that *inner healing* is a vital part of the process of becoming healthy (cf. 3.3.3). His compassionate response to those in need demonstrates that true *healing* is bringing *wholeness* not only to one's body but also to one's emotions and inner being (Ellel Ministries, 2005). It is interesting to note that the two words *wholeness* and *health* have the same Germanic root: *to be healthy is to be whole* (Zohar & Marshall, 2001:29).

Inner healing is part of Jesus Christ's redemptive work in one's spirit and soul (Edmiston, s.a.). For wounded and hurt people it can be a huge step forward in their Christian walk, enabling them to relate to others, and even to God with greater clarity and without the static of emotional pain. Edmiston (s.a.) also points out that there are a few effective and useful techniques that have been discovered, including Theophostic counselling. Healing from emotional pain enables people to read the Scriptures in a more balanced way and be less erratic in pursuing sanctification. Inner healing, however, is not a substitute for discipleship or holiness but can be useful "roadside medical attention" in the race called life.

Inner healing exists, based on a biblical indicative (Anon, 2001b). In Psalm 34:18 one reads that "the Lord is close to the broken-hearted, and saves those who are crushed in spirit". It is clear from this text that people can be hurt by others and by circumstances in their lives. It is also clear from this that God loves the broken-hearted and cares for them in an active way.

Inner healing is a ministry that seeks to deal with inner emotional pain (cf. Campbell-Lane & Lotter, 2005:99). The inner pain may be present due to negative life experiences. In the thoughts of those who practice inner healing ministry, the negative experience is the cause of emotional pain that people carry with them long after the damage occurred (Anon, 2001b).

Edmiston (s.a.) explains that inner healing has gained a bad reputation because of certain unprofessional and misguided practitioners who perhaps went searching for traumatic memories or who imposed "their own stuff" on people they were trying to help. He further states that there is also a genuine reservation among people who are Bible-believing because "*inner healing* is not in the Bible", unlike *physical healing*. According to Edmiston (s.a) true Christian *inner healing* has the following characteristics:

- It is focused on the redemptive work of Jesus Christ as recorded in the Scriptures.
- Afterwards the person is more able to obey God and to pursue sanctification.
- However, it does not pretend to be a form of sanctification or to substitute for sanctification. Sanctification is more than emotional healing – it is the development of character – the character of Jesus Christ.
- Afterwards the person tends to "just feel normal". The pain has gone and they feel normal, whole and able to function.
- It involves healthy relationships between the counsellor and counselee. There is no dominance, intrusion, "headship" or control. The relationship is healing and freeing.
- Memories, if explored are neither manufactured nor denied but simply treated as facts.

True Christian *inner healing* is firmly grounded in all aspects of the truth; biblical truth, factual truth and moral truth (Edmiston, s.a). The person is brought into the light of God's Word, the light of logic and right thinking and factuality and the light of repentance and forgiveness. Inner healing is the application of the grace and peace of Jesus Christ to the pain and confusion of the damaged emotional life. It is bringing the emotional world the "right side up". Edmiston (s.a) further explains that the practice of inner healing is varied, but inevitably involves encountering the truth of God and the presence of God in a secure atmosphere of loving and believing prayer. It is "in Spirit and in Truth". The first provision which Horowitz (2002:169) identifies as necessary to experience miraculous healings and be blessed beyond measure, is to develop one's *faith* in God.

Attitude and behaviour patterns can play an important role in emotional healing. According to Colbert (2003:152), some people develop distortional thinking about their ailments (cf. 2.3.3). Their identities seem clouded by toxic emotions that arise from a warped and broken belief system. Chronic guilt and shame can lead to deep depression (Colbert, 2003:84). Guilt and shame are both rooted in what should *not* have occurred as much as in what *did* occur. Both guilt and shame create an endless circle of negative thinking (Colbert, 2003:85). These emotions *never* lead to emotional freedom, strength, or health – either emotionally or physically. With true guilt, one needs to forgive the person who wronged one, ask God for forgiveness, and then forgive oneself for any part one may have played (Colbert, 2003:87). With false guilt, one needs to recognise that one has not done anything wrong, ask God to help one walk freely from the person who sinned, and forgive the person who hurt one so one might truly be unburdened in one's emotions.

When mood and anxiety disorders are caused by sin it is important to confess the sin. When sin is left unconfessed, a wall goes up between a person and God (Omartian, 1991:55). Even though the sin may have stopped, if it has not been

confessed before the Lord, it will still way the person down, dragging him back toward the past he is trying to leave behind.

Recent discoveries in the field of "psychoneuroimmunology" (PNI) – the science dealing with the interrelationship between body, mind, emotions, behaviour, and immunity – reveals an intimate association between *spirituality* and immunocompetence (Horowitz, 2002:54). Science is beginning to explain how positive emotions and attitudes like love, self-esteem, and meaningful purpose in life, empower immunity against various illnesses (cf. Booth & Pennebaker, 2004:561). Thus, as a redeemed child of God, one should be appreciative of one's magnificence, how much God loves one, and one's spiritual connection. The feeling of significance is crucial to man's emotional, spiritual and social stability and is the driving element within the human spirit (McGee, 2003:11). The true source of one's value is the love and acceptance of God. According to Horowitz (2002:54), for health and longevity, one needs to be spiritually inspired while expressing one's unique purpose in life. Who one spends one's time with, matters (Amen & Routh, 2003:199). When one is with positive, supportive, and loving people one feels happier and more content, and one lives longer. Being around people who make one experience stress causes one's body to secrete excessive amounts of adrenaline, which makes one feel tense and puts one on one's guard.

In 1997, Koenig reported to the annual meeting of the American Psychiatric Association on research that he and Kenneth I Pargament of Bowling Green State University had conducted on the relationship between coping techniques and the mental health outcomes of older patients hospitalised with a variety of physical illnesses. Religious helping of others appeared to be a highly beneficial coping method related to better mental health (Koenig, 1999:141). They found that older people who coped with their physical illness by reaching out to offer spiritual support and comfort to others were less likely to be depressed, experienced higher quality of life, showed high levels of stress-related personal

growth, and were generally more cooperative. Koenig (1999:142) construes that this finding was consistent with the growing body of research that suggests people who provide close friendship and emotional support to others enjoy improved well-being. Religious helping provides an empowering sense of value and purpose that promotes inner tranquillity and eases emotional pain. Praying with and for another person is an act that is simultaneously intimate and dignified, which elevates a person above the unpleasant physical reality of his affliction or condition. One of the most important findings of this research study is that people are multidimensional beings who have the strength and resolve to mobilise themselves when their bodies are afflicted. Moreover, by mobilising that strength and resolve to assist others spiritually, people help themselves, both physically and emotionally (Koenig, 1999:143).

According to Dyer (2006:228), people must rely on how they feel to determine their state of health, rather than seeking their answers in a medical printout full of numbers. Feeling energised, content, excited, and happy are better indicators of one's health and well-being than having one's bodily functions assessed by a distant laboratory.

Minirth and Meier (2002:176-193) are of the opinion that people will obtain happiness for life if they live by the principles of God instead of the naive principles of this pagan world. Their advice for finding lifelong happiness has been summarised in table 4.2 as follows:

Advice for finding lifelong happiness (Minirth and Meier, 2002:176-193)

Advice	Explanation/ Other references
1. *Change the* way *one talks to oneself.*	- Quit condemning oneself (cf. Jantz & McMurray, 2003:76). - Look at one's accomplishments instead of dwelling on past failures.
2. *Understand one's feelings but focus on behaviour.*	- One's actions (godly actions or ungodly actions) will determine how one feels. - One needs to understand one's feelings. - One needs to focus on one's behaviour. One should determine to ground one's behaviour in sound logic and firm biblical convictions. - Therapists have often tended to go to one extreme or the other in dealing with people's feelings versus their behaviour. Psychoanalysts or Gestalt therapists emphasize feelings. Therapists from the schools of behaviour modification or reality therapy or cognitive therapy emphasise behaviour or the way one thinks (cf. Gilbert, 2001:xiii). All of these aspects should be dealt with.
3. *Focus on a specific plan of action.*	- Implement a specific plan of action for overcoming one's depression (cf. Crabb, 1997:162). - Commit oneself to this plan, and work on it from day to day.
4. *Develop new interests and activities.*	- The depressed individual often gets in a rut. - Force oneself to develop new interests and activities (cf. Gilbert, 2001:180).

Advice	Explanation/ Other references
5. *Utilise the resource of prayer.*	- Prayer is a tremendous resource at the disposal of the depressed individual (cf. Omartian, 1991: 41, 43). - Through prayer one can incorporate supernatural strength. - Prayer is more than positive thinking; it is more than the power of suggestion; and it more than magical thinking, which some psychiatrists would call it. - Prayer is calling upon the power of God Himself who is available to His children (cf. 1 John 5:14, 15).
6. *Utilise the resource of the Word of God.*	- Individuals want freedom from their depression. This freedom can come through the Word of God (cf. Hagin, 2003:1). - The Word of God has tremendous power – power for many things, including overcoming depression. - The key to overcoming one's problems through the Word of God lies in loving, studying, and meditating upon the Word (cf. Omartian, 1991:35; Meyer, 2002:178).
7. *Develop a friendship.*	- Being alone can cause depression, or it can certainly reinforce a depression already present. - Developing a friendship can be of great assistance in overcoming depression (cf. Ecclesiastes 4:9, 10; Jantz & McMurray, 2003:82; Sutton & Hennigan, 2001:141). - Depressives are afraid to become close to others and therefore, they may develop defence mechanisms whereby they keep others at a distance. These defences are usually of 4 major

Advice	Explanation/ Other references
	types: denial, displacement, introjection and projection.
8. *Grow in fellowship.*	- A depressed individual can benefit tremendously from the body of Christ as a whole (cf. Ephesians 4:14-18; Crabb, 1997:9; Sutton & Hennigan, 2001:140). - Withdrawing reinforces depression.
9. *Realise that no one is perfect.*	- The depressed individual is unduly hard on himself, unwilling to forgive himself, and makes unrealistic demands upon himself (cf. Gilbert, 2001:327). - The depressed individual needs to realise that no one is perfect and that everyone makes mistakes and commits sin from time to time (cf. 1 John 1:8). - One needs to understand that one can benefit from one's mistakes and learn from them.
10. *Focus on assertiveness.*	- The depressed individual is often non-assertive. It is wrong to be aggressive, but it is also wrong to be passive. - To be assertive is to express in love and in a tactful way how one feels (cf. Gilbert, 2001:288).
11. *Deal with dependency needs.*	- Depressed individuals often have many dependency needs. However, they do not know how to take care of their dependency needs in a healthy way. - They may try to deal with their dependency needs by going to the opposite extreme and becoming very independent. They need to learn to deal with their dependency needs by going ahead and taking a chance on getting close to others.

Advice	Explanation/ Other references
12. *Recognise fear of rejection.*	- Depressed individuals are often caught up in a very unhealthy cycle. They have many dependency needs that may not have been met. However, while they have many dependency needs they have learned to expect people to fall short, which makes them very angry and hostile. This leads to rejection because they have set themselves up in such a way as to be rejected (cf. Gilbert, 2001:33).
13. *Deal with fear of rejection by changing behaviour.*	- Individuals who are depressed and going through the fear of rejection cycle, adding to their depression, can change this pattern by changing their own behaviour (cf. Omartian, 1991:238). - They must learn that they can get close to other people. They must learn that individuals will not always disappoint them.
14. *Recognise the anger.*	- Depressed individuals are often very angry individuals, and yet many of them do not realise this (cf. Plutchik, 2003:299). - As depressed individuals are able to recognise and admit their anger and gain insight into it, they begin to get better. - Furthermore, they must also go ahead and deal with the anger.
15. *Be careful with introspection.*	- Introspection is not good for depressed individuals, as much of this introspection is not objective. - Patients are encouraged to limit their time of introspection to therapy session, or perhaps to periods when they are talking to a close friend.

Advice	Explanation/ Other references
16. *Stop playing God.*	- In cases of depression the individual turns against himself and turns his anger on himself. - The depressed individual needs to learn to abide by God's will and stop punishing himself.
17. *Stop getting even.*	- Some depressed individuals use their depression to relieve themselves of their anger and get even with others. - They need to learn healthy ways to gain the attention they desire, and they need to find better ways to relieve their grudges.
18. *Accept responsibility for depression.*	- Many depressed individuals can begin to overcome their depression if they accept responsibility for their depression. By putting themselves in charge of their own lives they can begin to get better (cf. Philippians 4:13).
19. *Choose healthy ways to cope.*	- Many individuals reinforce their depression by continuing to cope with stresses in their lives through unhealthy means (cf. Gilbert, 2001:69). - A major way to ward off or to help overcome depression is to maintain a quiet time with the Lord everyday. It gives people supernatural help through the very Word of God itself.
20. *Realise there is hope.*	- Often the first step for the depressed person is for him to simply realise that there is hope.
21. *Avoid the sin trap.*	- One reason some individuals suffer from depression is that they are often involved in sin. They often react by engaging in even more sinful behaviour in an attempt to relieve the emotional pain they feel. - Much depression and grief can be avoided by

Advice	Explanation/ Other references
	refusing to engage in sinful behaviour (cf. Tan & Lyles, 2005:150).
22. *Avoid the guilt trap.*	- Depressed individuals feel a great amount of guilt (cf. Colbert, 2003:84; Brits, 2004b:85). - If the guilt is true guilt, then it is simply a matter of either confessing it to God (1 John 1:9), or perhaps dealing with that guilt in relationship to another person (Acts 24:16; cf. Jantz & McMurray, 2003:83). - If the guilt is false guilt, as is often the case in depression, the individual needs to educate himself concerning the grace and mercy of God (cf. Omartian, 1991:55).
23. *Manipulate the environment.*	- Individuals can recover from depression by either learning to cope with stress from within or by relieving the stress through environmental manipulation (do whatever they can to alter and relieve external stresses; Jantz & McMurray, 2003:108).
24. *Respond – don't react.*	- Many depressed individuals react very strongly when stressful situations appear. - If they learn to control their reactions and to respond rather than to react they begin to feel better about themselves and the way they are handling the situation.
25. *Increase self-esteem.*	- Individuals who are depressed usually have an extremely low level of self-esteem (cf. Gilbert, 2001:61). - Depressed individuals can raise their self-image by growing their relationship to Christ, growing in their

Advice	Explanation/ Other references
	relationships with other individuals and by setting realistic goals and working toward those goals.
26. *Approach the depression on a spiritual, psychological or physical level.*	- Another way to deal with depression is to approach it on a spiritual, psychological, or physical level, depending on which is involved (Colbert, 2003:46).

Table 4.2

Colbert (2003:186), however, is of the opinion that happiness is a feeling of pleasure, contentment or well-being that comes from the outer environment or event that a person is experiencing. It is temporary and dependent on external factors – including what others say and do. Joy, in contrast, is abiding and enduring. It comes from a feeling of contentment deep into the person. It is not dependent on external factors, but on an inner sense of value, purpose, fulfilment, or satisfaction.

According to Colbert (2003:186), pleasure that produces happiness tends to come through the five senses (cf. Jütte, 2005:4). As a result, happiness producing pleasures can induce an addiction. If one's goal is to find happiness through pleasures that are bound to the five senses, one will never be fully satisfied. Joy does not flow from situations. It flows from one's will and one's emotions deep within (Colbert, 2003:188). The author concurs with Colbert that one can choose to be joyful or choose to be miserable (cf. Philippians 4:4).

In conclusion, God's love, expressed through His people and woven into ones life by His Spirit and His Word, can over a period of time bring healing even to one's deepest wounds and instil within one an appropriate sense of self-worth (McGee, 2003:6).

4.6 PRELIMINARY CONCLUSION TO CHAPTER FOUR

In this chapter the *popular theological perspectives* on the healing power of faith in mood and anxiety disorders were studied. Brief conclusions from this study are summarised below.

Stress, *anxiety*, and related *depression* are now considered epidemic and the leading mental health disorder. *Anxiety* and worry are both attacks on the *mind* intended to distract people from serving the Lord. Christians are not exempt to depression and anxiety. The Bible does not use the words *mood* and *anxiety disorder* or *depression*, although it describes people whom might be suffering from it. Both psychology and the Scriptures point to the fact that anxiety can be either normal or abnormal.

Scientific studies linking the emotions and disease have produced an impressive body of research, all of which points to the conclusion that *what* one feels as emotions results in *how* one feels physically, emotionally and spiritually. However, people have separated church and state; medicine and spirituality; and healing and faith. This is resulting in a fragmented and incomplete approach to dealing with people's emotional and physical illnesses whenever it is linked. Health must be addressed holistically: physically, mentally, emotionally, socially, environmentally, and above all *spiritually.*

A precipitating cause of depression in many Christians is a *wrong perspective.* This is often caused by focusing on the wrong things. The minds of those struggling with anxiety disorders are riddled with contaminated thinking and erroneous thoughts about themselves, God, and their circumstances of life. Connecting with God through genuine repentance and renewing of one's mind to the truth of His Word will help one to fill one's mind with positive and constructive thoughts which are essential for the healing of damaged emotions.

CHAPTER FIVE

PRACTICE-THEORETICAL PERSPECTIVES ON THE HEALING POWER OF FAITH IN MOOD AND ANXIETY DISORDERS

5.1 OBJECTIVES

The main objective of this chapter is to propose an integrative/holistic faith-based model that can be used by pastoral counsellors in helping people to deal with their mood and anxiety disorders.

5.2 INTRODUCTION

In this chapter an attempt will be made to formulate a faith-based model drawing on biblical truths and examples, and facts and models from Spirit-inspired psychology and medicine, as well as treatment methodologies practised by these sciences. It must be noted that it is believed that God is giving scientists the intellectual capabilities to discover facts about emotional illnesses and behaviour and to develop treatment approaches. Some scientists, however, are basing their studies on non-biblical worldviews and the view of self.

5.3 HOLISTIC THERAPY: A METHODOLOGICAL MODEL

5.3.1 Introduction

The key results derived from the meta-theoretical perspectives (psychology and medicine, as discussed in chapter two); basis-theoretical perspectives (expository approach, as discussed in chapter three); and the basis-theoretical perspectives (popular theological approaches, as discussed in chapter four) regarding depression and anxiety will be used as a basis for developing the holistic faith-based model.

The model of Zerfass, (Zerfass, 1974:166; cf. Heitink, 1999:113; Heyns & Pieterse, 1998:34-37), will be used to derive at the new model. According to Heyns and Pieterse (1998:36) methodological models are a method of facilitating the interaction between theory and praxis. They conclude that:

> *The relationship between theory and praxis is one of bipolar tension. Theory is not praxis, nor is praxis theory. Yet the two are inseparably linked, like the two sides of a coin.* (Heyns & Pieterse, 1998:34).

Various diagnostic and treatment models have been proposed by psychology and medicine for treating people suffering from such mood disorders as depression and anxiety (cf. 2.3.8; 2.4.6). Selected models developed by theologians have been described in chapter 4. Three spiritually-oriented models will be discussed in 5.3.3. The proposed therapeutic model is to a certain extent based on the model of Zerfass as explained by Heyns and Pieterse (1998:34-37). It is a practical model which can be used by the counsellor to help a client from a particular praxis (psychopathological) to form a new theory/insight which can in turn lead to a new (healthy, balanced and insightful) praxis.

For the purpose of this thesis, Zerfass's model can be modified as follows to include the specific arguments described in the basis and meta-theories:

Application of Zerfass' model

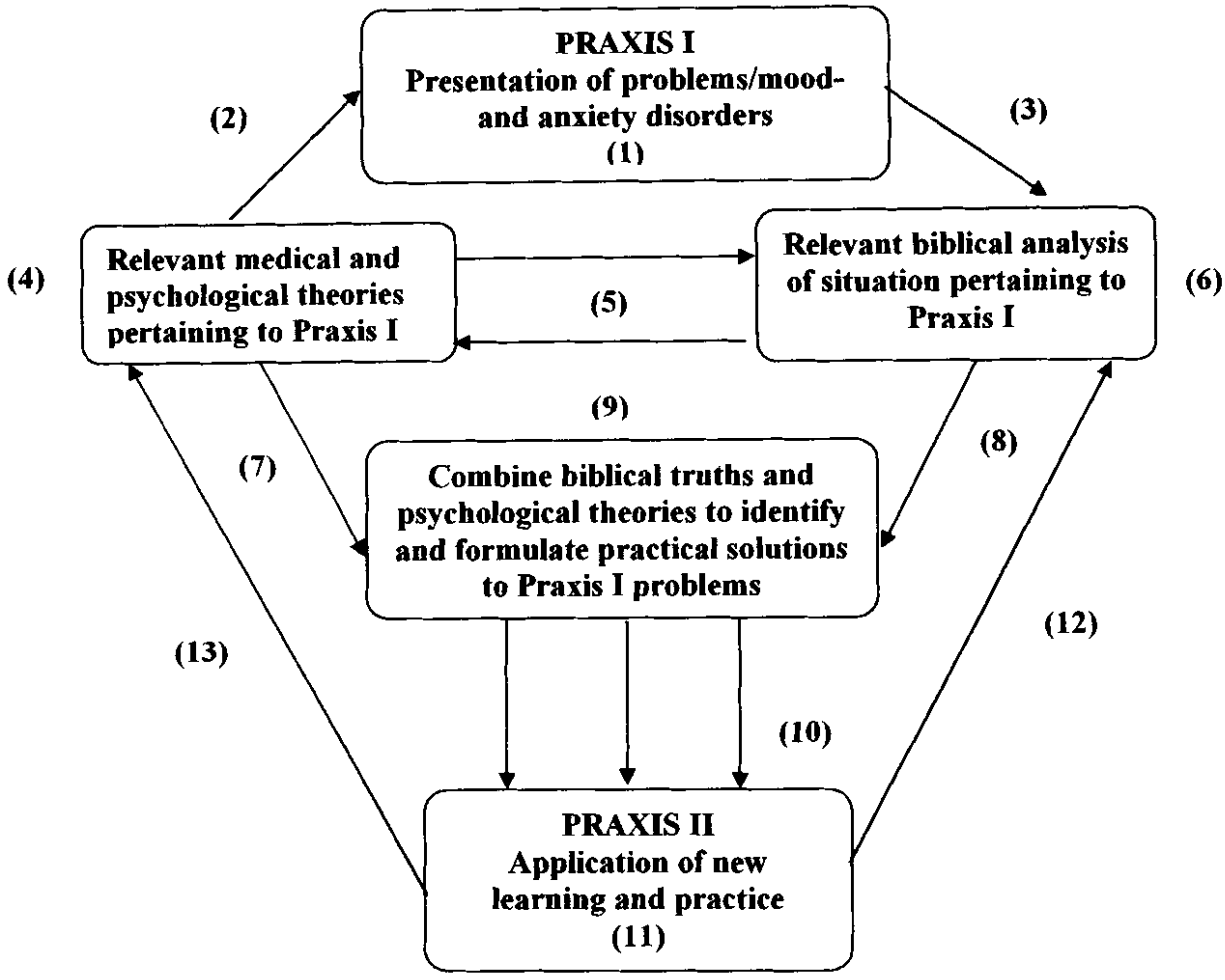


Figure 5.1

The upper square of the model is labelled *praxis I (1)*, and the lower square is labelled *praxis II (11)*. The model begins with praxis I and is completed with the formulation and application of the new amended praxis II. Praxis I may – for example – represent a client that is diagnosed with a mood and/or anxiety disorder which has a negative impact on the client's ability to perform his daily tasks. A therapist's first question may be: What are the underlying reasons for the client's symptoms? This is represented by arrow 2, namely the client's background information and particular life experiences which may explain the reason for the presented psychopathology of praxis I. The next step in this model entails a biblical analysis of the pathology as it is represented by praxis I. This is indicated by arrow 3, which points in the direction of the situational

analysis. Arrow 5 points to the fact that the background information of the client might have a direct bearing on the diagnosis that the therapist makes. On the other hand the reverse arrow 5 implies that the biblical analysis can explain that the negative background situation has an impact on the client's mood and anxiety disorder. This was the case for some of the biblical figures described in 3.3.4.

After examining the significant psychological theories relevant to praxis I (4), as well as the relevant biblical analysis (6), arrow 7 and 8 point to the actual therapeutic/counselling process (9), in order to facilitate improved mental health or healing from praxis I to praxis II.

The new learnt behavioural and/or emotional and/or cognitive patterns now need to be applied in practice (hence arrows 10) in order to create and establish the new praxis II (11). The new praxis also needs to be tested to determine whether indeed it provides healing answers for the praxis I (1) problems. The practical solutions (9) and the new praxis II need to be modified as a result of such an evaluation.

5.3.2 The phases and process of healing

Understanding the process of healing can be helpful in devising and implementing an appropriate treatment strategy for depression sufferers. Healing usually succeeds when approached in phases. For many mental and some physical disorders, one can benefit from paying attention to how the dimension of *time* relates to the process of healing. While all acute injuries need some time to heal, chronic ones tend to take more time. To help reach a successful repair and, eventually, growth, that time continuum can be divided into the following phases.

- *Phase Zero*

  Phase zero is active illness, and here healing has not yet begun. In this phase, one sees both symptoms and signs *and* other effects of whatever caused the illness. This active illness may be acute, recurring or chronic.

- *Phase One (Praxis I)*

  Reporting for treatment for any mental or physical disorder is the beginning of Phase One. It involves participating in a full recovery program to assist in healing the Phase One disorder. If one had "depression", one would often simply be prescribed an antidepressant drug, with little or no other investigation or intervention. Phase One is the conventional, one-sided treatment of mental disorders often using drugs alone. Unfortunately, this limited approach constitutes the bulk of the Phase One treatment today. Besides receiving drugs, a minority of people may get some brief counselling as well. However, that counselling is too often focused on only their current conflicts, and seldom on past traumas.

- *Phase Two (Praxis I or beginning of Praxis II)*

  The typical motivation for beginning Phase One recovery is the experience of too much hurt – emotional pain, physical pain or debilitating disease. Eventually, however, somewhere during, or more often after Phase One recovery, people may realise that they are still hurting.

  Phase Two recovery involves healing the effects of childhood and later trauma, including working through related core issues. Some mental disorders, especially those such as addictions (which often cause depression and anxiety), severe affective disorders (depressions and bipolar disorder), some personality disorders, dissociative disorders and psychosis usually require a year or more to reach enough *stability* to be able to engage in Phase Two work. For a history of trauma that has

is started under the supervision of a Christian counsellor and is continued by the client as soon as the mood swings and emotional pain have sufficiently subsided. As the client grows in faith, the magnitude of the mood swings reduces. If during this Phase healing has not occurred, the client is at a minimum better able to cope with the depression and or anxiety and feels more in control of his/her life.

The power of faith healing may be illustrated as follows in figure 5.2:

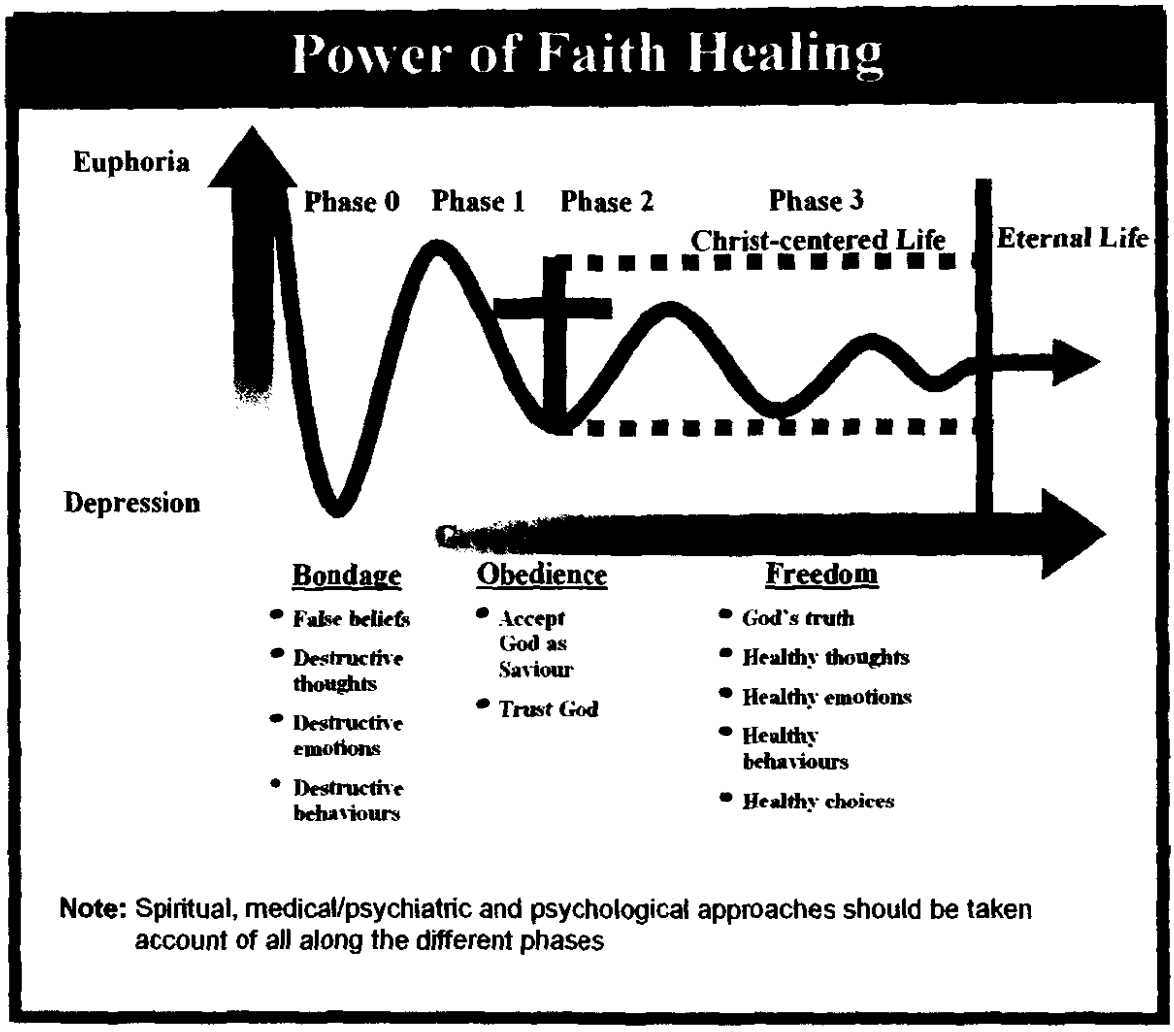


Figure 5.2

Various models for treating mood and anxiety disorders have been developed and are practiced by medical professionals and clinicians. This will be described next.

5.3.3 Psychosocial and medical approaches to treating mood and anxiety disorders

The treatment of patients with mood disorders must be directed at several goals (Sadock & Sadock, 2003:560):

- The patient's safety must be guaranteed.
- A complete diagnostic evaluation of the patient must be carried out (Praxis I).
- A treatment plan that addresses not only the immediate symptoms but also the patient's prospective well-being must be initiated.

Although most studies indicate, and although most clinicians and researchers believe that a combination of psychotherapy and pharmacotherapy is the most effective treatment for major depressive disorder, some data suggest another view, namely that either pharmacotherapy or psychotherapy alone is effective, at least in patients with mild, major depressive episodes, and that the regular use of combined therapy adds to the cost of treatment and exposes patients to unnecessary adverse effects (cf. Sadock and Sadock, 2003:561; Tan & Ortberg, 2004:40; Tan & Lyles; 2005:153).

For many people with depressive or anxiety disorders there are a number of psychological issues that need to be addressed. Without the proper biological treatment, psychotherapy can be a fruitless and frustrating experience for both the therapist and the patient. This is not to say that psychotherapy is not a necessary component of treatment, but it often needs to be done in combination with the right biological treatment, as anxiety and depressive disorders have strong neuro-biological underpinnings (cf. Amen and Routh, 2003:106). This viewpoint is supported by the author.

Getting along with others is often difficult for people with anxiety and depression. In treating people of all ages with anxiety and depression, it is often important to include an interpersonal psychotherapy in the treatment (cf. Amen & Routh, 2003:110). Three types of short-term psychotherapies – cognitive therapy, interpersonal therapy, and behaviour therapy – are described by Sadock and Sadock (2003:561-564):

Feature	Psychodynamic Approach	Cognitive Approach	Interpersonal Approach
Concept of pathology and cause:	Ego regression: damaged self-esteem and unresolved conflict due to childhood loss and disappointment.	Distorted thinking: dysphoria due to learned negative views of self, others and the world.	Impaired personal relations: absent or unsatisfactory significant social bonds.
Major goals and mechanisms of change:	To promote personality change through understanding of past conflicts; to achieve insight into defences, ego distortions and superego defects; to provide a role model; to permit cathartic release of aggression.	To provide symptomatic relief through alteration of target thoughts; to identify self-destructive cognitions; to modify specific erroneous assumptions; to promote self-control over thinking patterns.	To provide symptomatic relief through solution of current interpersonal problems; to reduce stress involving family or work; to improve interpersonal communication skills.

Feature	Psychodynamic Approach	Cognitive Approach	Interpersonal Approach
Primary techniques and practices:	Expressive-emphatic: fully or partially analysing transference and resistance; confronting defences; clarifying ego and superego distortions.	Behavioural-cognitive: recording and monitoring cognitions; correcting distorted themes with logic and experimental testing; providing alternative thought content; homework.	Communicative-environmental: clarifying and managing maladaptive relationships and learning new ones through communication and social skills training; providing information on illness.
Technique advantages:	Free association provides verbal catharsis; interpretations provide new understanding of depressogenic conflicts and historic events.	Specific approach is directly tailored to depressed population and aims at particular target symptoms; identification of depressogenic assumptions and homework to test new thinking and foster cognitive modification.	Specific approach is directly tailored to depressed population and can address particular current interpersonal maladaptions.

Feature	Psychodynamic Approach	Cognitive Approach	Interpersonal Approach
Technique limitations:	No specific techniques developed; focus on past events and spontaneous associations may encourage repetitive litany of depressive complaints at the expense of present therapeutic tasks.	Emphasis on specific cognitive schemata may bias toward certain preconceived themes; overt simplicity of techniques may lead to underestimation of technical skills required.	Identification of specific interpersonal problems areas may be overly restrictive, yet techniques are relatively non-specific; legitimation of patient sick role may encourage passivity.
Pharmacotherapy approach:	Medication is avoided except in life-threatening situations, used judiciously for severe vegetative signs.	Pharmacotherapy and cognitive therapy alone are in ongoing competition but drugs are used in case of poor response to cognitive therapy and for breaking psychotherapeutic impasses in severe depression when symptomatic relief is required.	Interpersonal therapy and pharmacotherapy are considered having different effects and response time-tables (early drug effects on vegetative symptoms later psychotherapy effects on suicidal ideation, work, and interests).

Table 5.1

Patterson *et al.* (1998:180) list the following *guidelines* to follow when working with *depressed* people and their families:

- Check for a family history of depression.
- Consider medication for the depressed family member as an efficient, cost-effective treatment option.
- Consider how the marital relationship influences the member's depression (by asking him or her about it).
- Note other family members' responses to the depressed member (e.g., distancing, empathising, hostility, over-involvement, criticism).
- When a parent is depressed, assess the impact on the children.
- Look for depression masked as other symptoms (e.g., irritability, anger, withdrawal).
- Consider treatment options including individual therapy (especially cognitive-behavioural treatments), couple therapy, family therapy, and group therapy and match treatment to the specific needs and wishes of the clients.
- Use psycho-education to inform family members about depression.

In addition to the above-mentioned guidelines, Jongsma and Berghuis (2000:68-75) propose the following additional *therapeutic interventions* for *depression* sufferers:

- Refer the client to a physician for a complete physical examination to rule out medical etiologies for depression.
- Review the client's use of stimulants (e.g. nicotine, caffeine, or street drugs), and depressants (e.g., alcohol, or barbiturates) and their possible symptoms.
- Teach the client positive, reality-based self-talk techniques (e.g. what to say when one talks to oneself).
- Refer the client for sleep disorder evaluation.
- Refer the client to a dietician or nutritionist to evaluate needs for increasing appetite or food intake.

- Refer the client to an activity therapist to identify social and recreational skills, and to develop a plan for exercise or social involvement.
- Teach the client deep muscle relaxation and deep breathing skills.
- Teach/refer the client to training in assertiveness skills.
- Refer the client to a support group for individuals with chronic mental illness concerns.

Marital and family therapies to treat depression generally work best for clients with mild depression and have shown to be less effective for severely depressed persons (Patterson *et al.* 1998:181). Patterson *et al.* (1998:186) provide several clinical *guidelines* for working with *anxious* clients and their families:

- For panic disorders and phobias, consider cognitive-behavioural treatments.
- Consider the role family conflict or marital conflict has in influencing the member's anxious symptoms.
- Consider covert or hidden relational interaction that influence the member's anxious symptoms (e.g. the partner's need to "control" and "protect" the anxious member).
- Consider the "place" or "function" of the anxious symptoms in the family system and the marital system.
- When treating anxious children, evaluate how the parents cope with stress and what coping skills they have taught their children.

In addition to the above-mentioned guidelines Jongsma and Berghuis (2000:46-54) proposes the following additional *therapeutic interventions* for *anxiety* sufferers:

- Train the client in guided imagery techniques (e.g. identifying several characteristics of a quiet, calm, serene or "surfing a panic attack").

- Teach the client deep muscle relaxation and deep breathing to reduce anxiety symptoms; utilise biofeedback techniques to facilitate relaxation skills.
- Review the client's use of psychoactive chemicals (e.g. nicotine, caffeine, alcohol abuse or street drugs) and their possible symptoms.
- Refer the client to a physician for an evaluation as to the need of psychotropic medications.
- Assist the client in identifying appropriate and available community-based social, vocational, or recreational programs or activities in which he/she could become involved.
- Refer the client to a self-help support group for anxiety disorders or chronic mental illness symptoms.
- Teach the client self-talk techniques.

The shortcoming of this and other models is that they do not focus sufficiently on the importance of faith in sustaining healing or inner peace. Therefore, three other spiritually-orientated models will be described below. Tan and Lyles (2005:154-156) integrated some of the main aspects or components of behaviour therapy, cognitive-behaviour, and interpersonal therapy within a biblical or spiritual perspective as follows:

A. (Affect): *Strategies for exploring and dealing with feelings associated with depression*

1. *Permission-Giving* to clients to talk openly about their struggles with depression.
2. *Attentive listening.*
3. *Empathic responding.*
4. *Use of feeling words, imagery, and/role-playing to help clients to express their feelings better.*
5. *Appropriate self-disclosure.*
6. *Identifying losses and working through grieving process.*
7. *Inner healing prayer for past hurts and painful memories.*

B. (Behaviour): *Behavioural interventions for treating depression*

1. *Self-monitoring*, using a weekly activity or log.
2. *Use of graded task assignment*, breaking down bigger tasks into smaller, more "do-able" or manageable units.
3. *Use of a "behavioural experiment"* to overcome perfectionism or shame.
4. *Assertiveness training*, using role-playing and modelling of appropriate, assertive responses.
5. *Relaxation/coping skills training* to reduce tension and help to control negative thinking and feelings.
6. *Listening to music and engaging in other pleasant activities.*
7. *Taking care of the body* (e.g. with good nutrition, regular exercise and adequate sleep of eight hours a night).
8. *Use of "light boxes" or special light bulbs* if the client is suffering specifically from Seasonal Affective Disorder (SAD).

C. (Cognition): *Helping depressed people change distorted thinking*

1. *Use of an "ABC" Diary,* with A for Activating Event or Situation, B for Belief or Self-Talk, and C for Consequences (Feelings and Behaviours).
2. *Thought-Stopping* to temporarily stop recurrent negative thinking by shouting "STOP" and eventually saying "STOP" sub-vocally to oneself.
3. *Cognitive restructuring*, the mainstay of cognitive therapy, to help the client change negative, distorted thinking into more accurate, realistic, biblical thinking.
4. *Prayer with thanksgiving* (Philippians 4:6-7).
5. *Use of humour.*
6. *Bibliotherapy (homework reading).*
7. *Use of contemplative prayer and meditation on Scripture and other spiritual disciplines for learning to Rest in the Lord.*

Willard's model of the person as well as some of his observations concerning the process of authentic transformation is presented in figure 5.3 as an illustration of a (character) change approach (Moon & Crews, 2005:189).

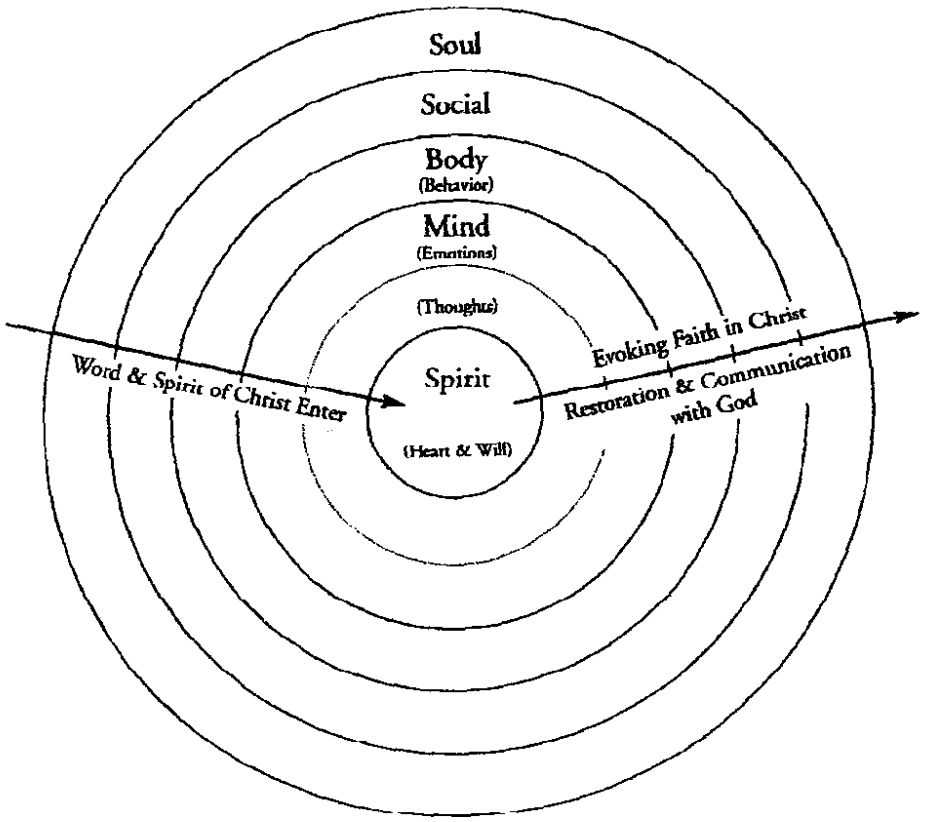


Figure 5.3

The soul is a component of a person – that aspect of the self that integrates all the other aspects *into* one life – and it is also the whole, the person. The soul is a part *and* the whole. As illustrated in figure 5.3, transformation is the process whereby the whole self is restructured from the inside out. Spiritual growth is the process of authentic transformation of each of the rings of the figure – of each of the aspects of the person. Transformation is a matter of the heart and will, the mind (thoughts and emotions), the body, and interpersonal relationships all becoming a consistent reflection of the whole life of Christ. Character change is a form of will-alignment. It involves growth in the ability to surrender one's will to the will of God. Willard's model represents the soul as the natural capacities of

a person to **choose** or will, to represent or think, to feel (sensate and emotional), and to behave and interact with others (cf. Willard, as quoted by Moon & Crews, 2005:189, 190; Joubert, 2005:193).

Transformation of the soul means deep internal change, which is possible only through the mystery of Christ within (Colossians 1:26-27) and the evoking of **faith** in Christ to live and act through people. As part of the process, all aspects of the person begin to function as a whole and as a more focused reflection of the character of Christ (cf. Moon & Crews, 2005:191).

The concept of the soul was all but lost to modern psychology, a fact that has been well documented. In light of Willard's uniting model of the various aspects of the person, it seems particularly interesting that psychology has, at times, become fixated on various parts of the whole – unconscious processing (psychodynamic approaches), body (behaviourism), mind (cognitive psychology), and interpersonal (interpersonal and social psychology). Psychology without consideration for the (whole) soul has been prone to compartmentalisation – even fragmentation. Willard's model illustrates the importance for a holistic approach and why a psychological approach by itself is not sufficient (cf. Moon & Crews, 2005:191).

Minirth and Meier (2002:172-173) list ten *behaviour patterns and attitudes* taken from Scripture, as described in Philippians 4, that will decrease or help overcome *anxiety*:

1. Determine to obey God. God commands people not to be anxious (Philippians 4:6).
2. Pray (Philippians 4:6). God told Daniel not to fear because God had heard his prayer from the time he first started praying and *He would answer* (Daniel 10:12).
3. Realise that God can keep one's mind safe as one obeys Him (Philippians 4:7).

4. Meditate on the positive thoughts (Philippians 4:8). One has often encouraged people who catch themselves worrying to say, "Stop, relax; anxiety is a signal to relax, so relax." One then encourages them to ponder over a verse like Philippians 4:8. Anxiety is usually a signal to become more anxious, but by a simple technique of behaviour modification the brain can be conditioned to use anxiety as a signal to relax. There is no better place to find positive things to meditate on than the Scriptures (Psalm 34:4; 86:15; Proverbs1:33; 3:25,26; Isaiah 40:28-31; Matthew 6:33,34; 11:28-30; John 10:27,28; 14:27; 2 Corinthians 11:3; Hebrews 4:15; 1 John 3:20; 4:10).
5. Focus on godly behaviour (Philippians 4:9). One often tell anxious individuals to avoid sin (Proverbs 4:15), and to join small fellowship groups (Hebrews 10:24, 25).
6. Divert attention from self to others (Philippians 4:10; 2:3, 4). As an individual gets his mind off his own problems by helping others, his anxiety often decreases.
7. Work on being content (Philippians 4:11; 1 Timothy 6:6).
8. Realise there is a twofold responsibility (one's and Christ's) in doing anything. "I can do all things through Christ ..." (Philippians 4:13). An individual can overcome anxiety through Christ.
9. Eliminate the fear of poverty (Philippians 4:19). God promises to supply all one's needs (not all one's wants).
10. Realise that the grace of God is with one (Philippians 4:23; 2 Corinthians 9:8).

In addition to these ways for overcoming anxiety that are taught in Philippians, Minirth and Meier (2002:173) also suggest these *common sense* guidelines:

1. Listen to Christian music (1 Samuel 16:23).
2. Get adequate exercise – ideally three times per week for at least 20 minutes each time. Consult one's physician for the extent of exercise safe for one. Vigorous exercise releases endorphins into one's bloodstream that makes one feel happier and more energetic.

3. Get adequate sleep (Psalm 127:2). Most people need eight hours of sleep per night.
4. Do what one can to deal with the fear or problem causing the anxiety. Examine different alternatives or possible solutions and try one.
5. Talk with a close friend at least once a week about one's frustrations.
6. Get adequate recreation – ideally two to three times per week.
7. Live one day at a time (Matthew 6:34). Probably 98 percent of the things one is anxious about or worries about never happen. Learning to live one day at a time is an art that can be cultivated.
8. Imagine the worst thing that could possibly happen, and then consider why that would not be so bad after all.
9. Do not put things off. Putting things off causes more anxiety.
10. Set a time limit on one's worries.

Once the counsellor has finished the counselling it is important that the counselee is adequately equipped to deal with potential recurring depression or anxiety spells. Regular prayer, studying of Scriptures, involvement in a faith-community, filling of the mind with positive thoughts (cf. Philippians 4:8) and biblically-based choices are critical for achieving and sustaining healing and/or inner peace.

5.3.4 Holistic faith-based model

Every counsellor has a theology – along with a spirituality, bio-medical theory, psycho-social theory – that directly influences the counselling process. Religious beliefs provide a worldview that is positive, coherent, optimistic, and caring. Religion gives purpose and meaning which is particularly true for people undergoing negative life experiences or difficult situations – and that includes those with mental or emotional problem. Christian counselling is largely deficient in its theological roots and spiritual practices (cf. Koenig, 2005:134, 136; Clinton & Ohlschlager, 2005:17).

It is believed that biomedical and psychosocial approaches, in combination with Christian counselling, have an important role to play in treating depressed or anxious clients. Effective counsellors are those given to "multitasking" – the ability to utilise insights and skills gained from the study of theology, psychology, and spirituality simultaneously and appropriately for the benefit of the client (cf. McMinn as quoted by Clinton & Ohlschlager, 2005:17).

God created mankind with different dimensions, such as theological, philosophical, ethical and biological dimensions. From the Christian perspective, therefore, these categories are sacred and not secular, because they are imprinted in the creative order (cf. Anderson *et al.* 2000:34).

A *conjoint therapist* counsels from a Christian worldview and embraces both spiritual resources and compatible insights and methodologies from the sciences and mental health. Counsellors cannot undo or fix the past, but it is believed that by the grace of God people can be set free from the hurts of their past; when they realise their freedom in Christ, they can be all God has created them to be (cf. Anderson *et al.* 2000:81).

A number of randomised clinical trials have tested the effectiveness of religious interventions in religious patients with depression and anxiety. These have included Christian cognitive-behavioural therapy, Christian rational emotive therapy, Islamic therapy using the Qur'an and prayer, and Tao cognitive therapy. The majority of these clinical trials have found that religion-based psychotherapies with religious patients are more effective than secular psychotherapies or no treatment (cf. Koenig, 2005:145).

For the purposes of this thesis, the term *holistic*, should be understood as the integration of biblical truths and the biblically sound perspectives from the medical and psychiatric disciplines.

It should be noted that the target group, for which the holistic faith-based model is intended, is people searching for counselling of their mood and anxiety disorders from a Christian perspective.

The following therapeutic approach is put forward for mood and anxiety disorders as a *proposed practical framework* within which the holistic faith-based therapy can be applied:

- Conduct the initial assessment.
    - Explore presenting problems.
    - Diagnose, in collaboration with a psychiatrist or psychologist (areas 6 and 7 in figure 5.3 to follow), using a DSM-IV multiaxial assessment and other psychosocial rating scales.
- Develop an individual treatment plan (choose appropriate interventions).
- Describe the holistic faith-based treatment approach.
- Implement the treatment plan.
- A final imperative for concluding the treatment includes a session devoted solely to reinforcing the importance of *faith* in ensuring lasting *healing* and/or peace, or coping with the mood and anxiety disorder. The counselees are provided with a pocket-size reference guide with helpful tips to remind them on a daily basis how they should live to become more Christ-like and find everlasting peace.

Before describing the holistic faith-based approach for mood and anxiety disorders, it is important to differentiate between the terms *counselling* and *psychotherapy*. These terms seem interchangeably to many people, however, they tend to have different meanings for people in the helping professions. Generally, counselling is understood by helping professionals to be a relatively short process, often occurring in one session and rarely comprising more than five sessions, whereas psychotherapy usually runs for many sessions and can even continue for years. Counselling is usually seen as problem-oriented, while psychotherapy is person-oriented. As the following table indicates, the actual processes that occur in counselling and psychotherapy are identical, but they

do differ relative to the time spent, and thus quantity affects quality. Counselling and psychotherapy are the same qualitatively; they differ only quantitatively. There is nothing that a psychotherapist does that a counsellor does not do (cf. Corsini & Wedding, 1995:2).

Essentially, counselling stresses the giving of information, advice, and orders by someone considered to be an expert in a particular area of human behaviour, while psychotherapy is a process of helping people discover why they think, feel, and act in unsatisfactory ways. A counsellor is primarily a teacher, while a psychotherapist is essentially a detective (cf. Corsini & Wedding, 1995:3).

Estimate of percent of time spent by "counsellors" and "psychotherapists" in professional activities (Corsini & Wedding, 1995:2)

Process	Counselling	Psychotherapy
Listening	20	60
Questioning	15	10
Evaluating	5	5
Interpreting	1	3
Supporting	5	10
Explaining	15	5
Informing	20	3
Advising	10	3
Ordering	9	1

Table 5.2

The connection/correlation between psychiatry, psychology (psychotherapy) and pastoral counselling also needs to be clarified. From the following figure, it can be argued that each of these helping disciplines have a clear identity/domain (compare areas 1, 2 and 3), however, they also overlap to some extent in terms of specific aspects (compare areas 4, 5, 6 and 7).

The connection/correlation between psychiatry, psychology (psychotherapy) and pastoral counselling (Joubert, 2006)

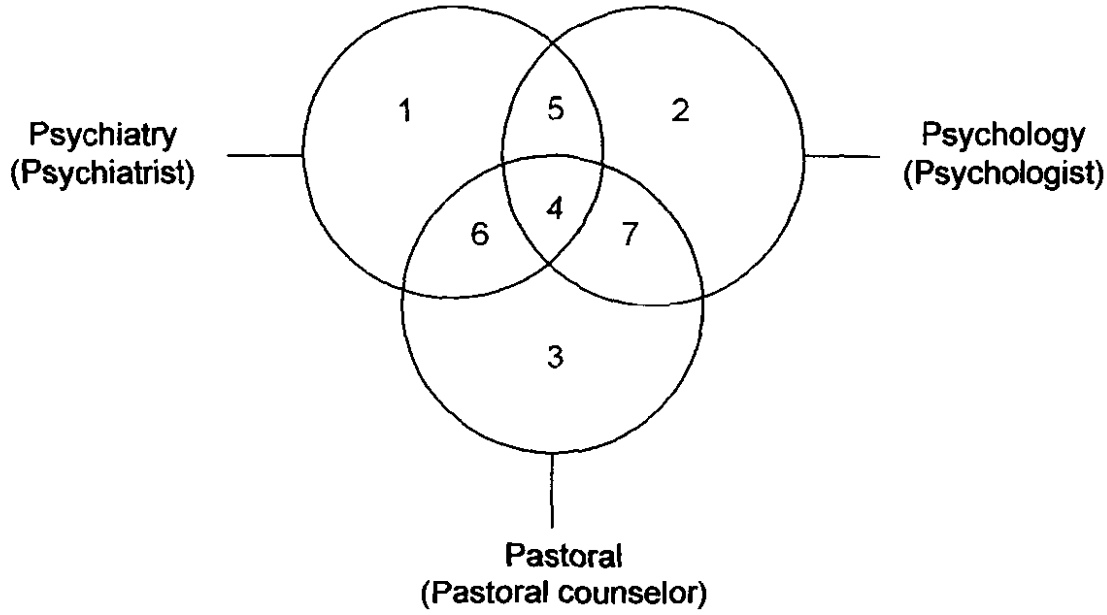


Figure 5.4

1. **Psychiatry**

A psychiatrist is a medical practitioner with postgraduate training and qualifications in psychiatry. Psychiatry, therefore, is the branching of medicine that specialises in the diagnosis, treatment and prevention of psychopathological conditions (cf. 2.3). The treatment by a psychiatrist comprises primarily of the prescribing of psychopharmacological medication as well as (to a slighter degree than traditionally a psychologist), the application of psychotherapy. Some psychiatrists also make use of techniques such as electroconvulsive therapy and narcoanalysis. A psychiatrist is therefore registered with the *Health Professional Council of SA (HPCSA)*. A psychiatrist and psychologist often work together as a team; the psychiatrist will prescribe and monitor the necessary medication for the diagnosed pathology of the patient, while the psychologist will practice psychotherapy (cf. Joubert, 2006).

2. Psychology

A psychologist is a person that has postgraduate qualifications in psychology and is active in one of the branches of psychology. The law determines that only a person that has at least a magister degree in psychology, has done an internship and is registered as a psychologist with the HPCSA, may be called a psychologist. Present-day psychology comprises of diverse divisions/branches: general psychology, physiological psychology, developmental psychology, social psychology, experimental psychology, psychopathology, personality psychology, psycholinguistics, environmental psychology, industrial psychology, personnel psychology, counselling and educational psychology, clinical psychology, pastoral psychology, mathematical psychology, differential psychology, psychometrics, comparative psychology and animal psychology.

A psychologist usually works closely with a psychiatrist in the treatment of a patient's psychopathology. The psychologist, therefore, primarily practices psychotherapy, while the psychiatrist primarily prescribes and monitors the psychopharmacological medications for the particular psychopathology (cf. Joubert, 2006).

3. Pastoral Counselling

Traditionally pastoral counselling is part of the duties of a minister/pastor/spiritual leader and relevant training in this discipline is part of his/her formal academic training. From his/her duty as a pastoral counsellor, the minister can get in touch with a psychiatrist or psychologist about a member of the congregation that has come for spiritual guidance and is manifesting with a possible psychopathology.

Although there are a number of international and national associations to which a pastoral counsellor can get membership, there is currently no national statutory (like the HPCSA) acknowledged by the government where a pastoral counsellor can professionally register. There is, however an initiating body that

is campaigning for the accreditation of Pastoral Counselling and Pastoral Care; it is the *South African Association of Pastoral Care* (SAAP). SAAP has been busy for quite a while with research and attempts to have Pastoral Counselling acknowledged and accredited by the government. This will have many advantages; like payments made by medical aids, credibility of the profession of Pastoral Counselling, standardising of training and maintenance of standards of training in practice and a liable ethical code for all pastoral counsellors. A large number of pastoral counselling courses and degrees are presently obtainable from different academic and educational institutions (cf. Joubert, 2006; Van Arkel, 1999:88; see also appendix C).

All three of the above-mentioned professions have unique roles to play, each on its own terrain. However, it is also clear that; due to the human being's complex nature; the three areas can mutually affect each other. Therefore, if required, it is also possible for these three professions to get together and to work together as a team.

In this regard, the psychiatrist (area 1, figure 5.3), psychologist (area 2) and pastoral counsellor (area 3) can get together, on an *ad hoc* basis, to discuss information regarding a specific patient/client, each sharing perspectives from their respective professions (area 4) in an effort to recommend the best treatment for the specific patient/client.

Figure 5.5 below depicts the *holistic faith-based approach* for dealing with mood and anxiety disorders. For the purposes of this study, the model will focus on clients suffering from major depressive disorder. It should be kept in mind that any combination of spiritual, medical, psychological and circumstantial issues can be the cause of the major depressive disorder.

Proposed matrix to be borne in mind in the spiritual, medical/psychiatric and psychological approaches

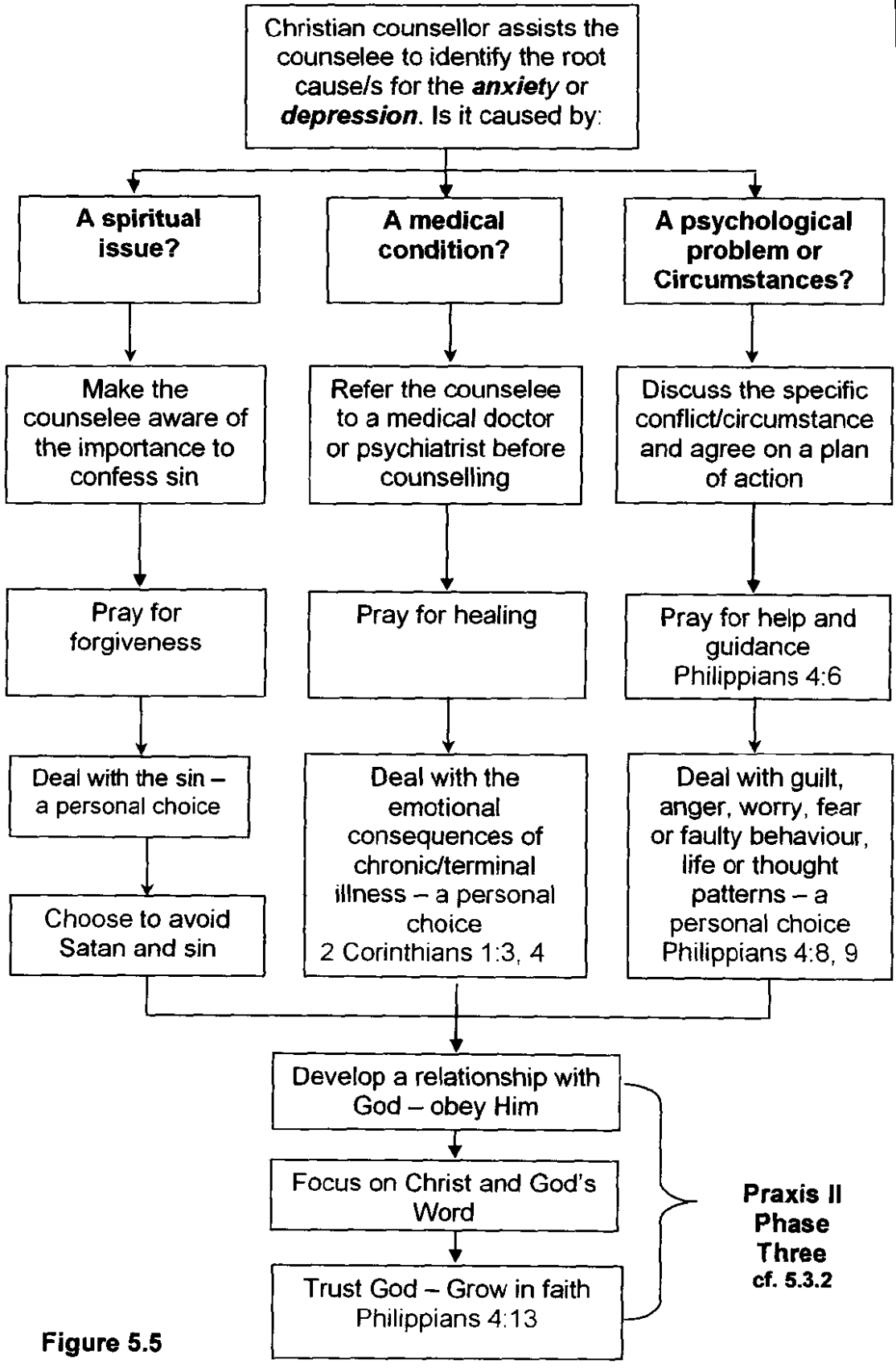


Figure 5.5

The model will be discussed according to the proposed matrix. The spiritual, medical/psychiatric and psychological treatment approaches during the different phases of healing/coping are summarised in table 5.3:

	Spiritual	Medical/Psychiatric	Psychological
Phase one	- Introduction of the value of spirituality in healing.	- Superficial treatment of mental disorders often using drugs alone.	- Brief counselling on current conflicts – excludes past traumas.
Phase two	- Christian counselling using God's Word as basis. - Employment of some of the Biblically tested psychosocial models and methods if deemed appropriate to teach the counselee healthier behavioural and cognitive patterns as well as new skills for dealing with the consequences of their depression.	- Administration of drugs and possibly some counselling. - Exercise. - Diet.	- Healing the effects of childhood and later trauma, including working through related core issues.

	Spiritual	Medical/Psychiatric	Psychological
Phase three	- Incorporation of spirituality into daily life. Living a faith-driven Christ-directed live. - Ongoing and lifelong process. - Learning to realise spirituality. - Psychological health is just one of its goals.	- Continuation of drugs. - Repeated transcranial magnetic stimulation and electroconvulsive therapy (ECT). - Possible hospitalisation for observation and treatment.	- Continued counselling using a broader range of or more advanced techniques. - Reference of client to a psychiatrist.

Table 5.3

Spirituality is the only approach that can bring about permanent healing and or peace for depression sufferers.

5.3.5 Phase One: Identification of root cause/s for and treatment of the depression

Following the diagnostic phase (Praxis I [1], figure 5.1), the counsellor, in cooperation with the counselee, determines whether the depression is caused by a spiritual problem (for example sin), a medical condition, a psychological problem, circumstances or a combination of any of these categories (4 & 6, figure 5.1). This information is used to prepare the appropriate faith-based treatment plan (9, figure 5.1) by combining biblical truths and psychological theories to identify and formulate practical solutions to Praxis I problems.

Knowing the cause of the illness is an important step in identifying the specific strategy to take towards healing. If the illness is caused by sin, then repentance is imperative. If the illness or physical problem stems from past emotional hurts, then forgiveness is required. If a physical problem is the result of a medical

condition or a physical disorder, then medical intervention is needed. If the illness is caused by circumstances then restoration or adjustment of whatever is causing the problem is called for.

Spiritual/Sin

One of the precipitating factors of depression is sin. One of the significant departures of psychopathological models is that almost none take sin seriously as a possible cause of illness. Rarely in current psychological thinking is one's personal responsibility emphasised. Even less often is individual accountability before God taken into account. This is in contradiction with the Christian worldview (cf. Faw, 2004:150).

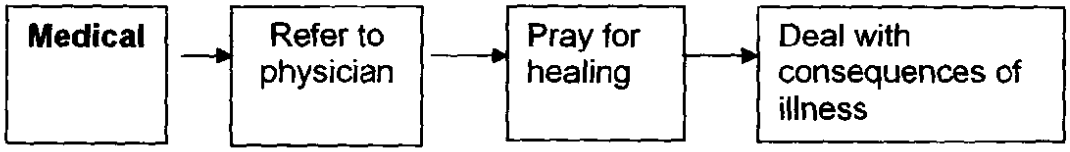
Possible sin-related causes of depression include negative attitudes like bitterness and hatred, guilt and lack of repentance over sinful behaviour or attitudes, turning away from God and His Word, fear of the future and lack of trust in God as sufficient provider, and unbelief in general (cf. Tan & Ortberg, 2004:34).

Christ desires that one **confesses one's sin.** Because of Jesus Christ, people can be changed into "new creations", all people can find forgiveness, and there is hope for genuine healing. The effects of sin are still with one, but one has to promise that in the future sin's impact will be gone (cf. Collins, 1993:112; 3.3.4 – David).

The counselee should be guided on how to **pray for forgiveness** of sin. Even though past sinful behaviours cannot be eradicated, God is merciful and will provide freedom from the impact of past sins. Once the counselee has prayed for forgiveness he/she should avoid dwelling on the past and orientate their actions toward changed patterns in the future. With God there is hope as one deals with the problem.

The counselee should make a conscious decision (choice) to **avoid temptation and sinful behaviours**. It should be remembered that one lives in a sinful world and that Satan will continue to tempt one.

A medical condition



If from the diagnostic analysis it is believed that the depression of the counselee is caused by a **medical condition**, the counselee is referred to a medical practitioner for confirmation of the illness and the necessary medical treatment. The premise of this model is that this is not sufficient by itself and that the counselee will benefit greatly from follow-up Christian counselling.

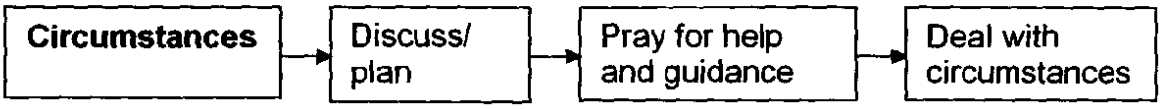
It is important that the counselee understand that all people can get depressed and that God can heal them not only from their illness but can also provide relief from their depression. The counselee should be made aware of the fact that medication is necessary if chemical imbalances exist, that they should not have any guilt feelings about their illness and that God has given scientists the expertise to discover medical interventions.

The counselee is guided on how to **pray for healing** and emotional peace. One may ask God to heal one, and rejoice if He does so. One may also rejoice, however, when He chooses instead to use one's weaknesses as a platform to display His grace and power in one's life. The true "prayer of faith" acknowledges God's sovereignty over each person's life. The prayer offered in faith reveals complete trust in God to do His will (cf. SCB, 2001:1650, 1653).

Many people suffering from a chronic or terminal illness get depressed and engage in negative behavioural patterns, such as negative self-thought, self-destructive actions, etc. The counsellor must endeavour to identify these negative behavioural patterns and help the counselee design a plan to **deal**

with these **negative emotional consequences**. It is here where the counsellor can borrow from some of the psychosocial models and methods to teach the counselee healthier behavioural and cognitive patterns as well as new skills for dealing with the consequences of their depression (cf. table 2.6; 2.4.6; Biebel & Koenig, 2004:136; Sadock & Sadock, 2003:562).

Psychological/Circumstances



There are wide-ranging external circumstances that can lead to depression (cf. 2.3.3). The underlying circumstance/s causing the depression should be identified and analysed. The counsellor should then prepare a **plan of action**. Depending on the underlying circumstances the counselee can be counselled using different psychosocial approaches and biblical truths. Examples from the Bible of people that encountered similar circumstances can be used to illustrate how these people handled their depression (cf. 3.3.4). The best insights can be obtained by studying the faith-filled and faith-driven life of Jesus Christ (cf. appendix B).

The first thing a Christian should do about negative circumstances is to **pray for help and guidance**; turning to God in prayer demonstrates one's reliance on Him. Even in the midst of depression one should turn to God in prayerful meditation – even though one may not feel like it. Prayer is powerful in dealing with emotional circumstances and connecting with God (cf. Anderson *et al.* 2000:272; Philippians 4:6).

The counselee should be taught how to deal with psychological problems like guilt, anger, worry, fear, faulty behaviour and life or thought patterns (cf. Mitchell, 2004:125-130). Several psychosocial methods and techniques, combined with biblical truths, can be employed to help the counselee overcome or cope with these issues. Two of these methods will now be outlined:

- *Cognitive-behavioural therapy* is indicated for use when biblical untruths and irrational beliefs are preventing clients from living a free and productive life. The basic premise is that Satan's lies are cognitive distortions of reality. This approach to spiritual and psychological problems helps to transform clients' minds and assist them in learning how to manage their emotions and to be set free from the strongholds of the world, the flesh, and the devil (cf. Zuehlke, 2000:223; table 2.6).

- The *Early Recollections technique* is indicated for use when clients' beliefs about themselves, others, the world, and/or God are being applied to every situation, no matter what the truth of the belief in a particular circumstance. The basic premise is that distorted beliefs are not based on the truth. The technique assists the client in uncovering the lies or distorted beliefs and gives him/her the opportunity to challenge those beliefs in light of reality and biblical truth (Kytta, 2000:233).

If forgiveness is required, one should seek to accomplish the following five goals as one works toward forgiveness (Jantz & McMurray, 2003:138):

- One should not seek revenge or do harm.
- One should have personal peace.
- One should not engage in self-destructive behaviour because of this person or event.
- One should be able to put what has happened to one into the context of one's present life.
- One should be able to accept oneself and others.

5.3.6 Phase Two: Application of new learning and practice

Irrespective of the root cause/s for the depression, the next phase is to lay the foundation for the application of new learning and practice (Praxis II [11], figure 5.1), which includes:

- Development of an ongoing relationship with the God of hope.
- Focusing on Christ and God's Word.
- Trusting God and growing in faith.

The DSM and similar schemes and categories are useful mostly in Phases Zero and One. They can have some usefulness in Phase Two recovery, such as in the case of alerting clinicians when people may have a personality disorder or another one to which they may need to pay special attention.

The problem with most other models is that it does not provide counselees with a toolbox of insights and truths for sustainable healing and/or peace. Therefore, the application of the Praxis II learning and practice as outlined above is considered to be indispensable. This is illustrated in figure 5.6.

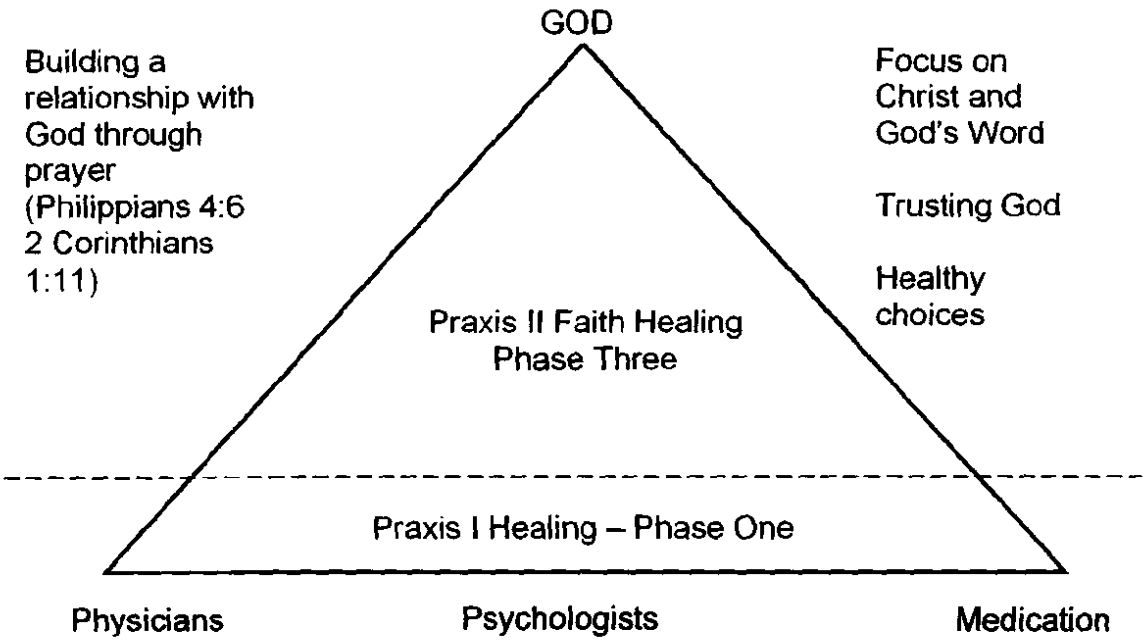


Figure 5.6

5.3.7 Phase Three: Recovery

Building an ongoing relationship with God is the first step in realising the application of Praxis II learnings. One must individually **receive** Jesus Christ as Saviour and Lord; then one can know God personally and experience His love. One receives Christ through faith.

Since human beings are wired for God, a healthy Christian spirituality often produces physical benefits. One should desire to maintain a consistent prayer life in communion with God. God heals in answer to faith expressed in prayer. Whether God heals one or not, He does renew one's strength. One's aim should be to avoid any psychological or spiritual obstacles that could disrupt one's dependence on Him. For ongoing health and healing, one needs the divine life of Christ flowing ceaselessly into one's mortal body (cf. Smith, 2005:79,187; Romans 8:11). One has the assurance that if one goes to God, one will receive mercy and find grace in time of need (cf. Anderson & Anderson, 2004:8).

Focusing on Christ and God's Word are essential for understanding Christ-like behaviours (cf. Philippians 4:9), Christian doctrines, for building a lasting relationship with Christ and for ongoing support in need. The promise of God's Word, the Bible – not one's feelings – is one's authority. To apply what the Bible says one has to understand the Scriptures. One needs to regularly read and meditate on the Word of God (cf. Philippians 4:8). When one meditates on the Bible, the Scriptures help to protect people from sin (Psalm 119:11), enlighten one (verse 18), counsel one (verse 24), gives one strength (verses 27-28), clarify one's values (verses 35-37), free one (verses 45-46), bring comfort (verse 52), give hope (verses 74, 81, 147), give one wisdom (verses 98-100) and understanding (verses 104, 169), guide one (verse 105, 133), and give one an inner peace (verse 165). People who meditate on the Bible are guaranteed to change in ways that will make them more Christ-like (cf. Collins, 1993:53).

Trusting God and growing in faith is important for healing but also for everyday Christian living. The Christian lives by faith (trust) in the trustworthiness of God Himself and His Word. Spiritual growth results from trusting Jesus Christ.

Healing and the work of the Holy Spirit is closely intertwined. When one gives oneself to God, God fills one with His Holy Spirit. Handing over one's body to God in full surrender and perfect trust is an exchange of one's weakness for His strength. The external power of Jesus Christ is made effective by one's *choice* to believe (cf. Smith, 2005:94; Omartian, 1991:125).

Recovery from depression is not a destination but a road that is walked. Some of the reasons for one's depression will be evident, and some one may never completely understand. Deeply buried answers take time to come to the surface, and God reveals truth on His own timetable. During these times, one must have *faith* that God is with one and trust His presence in one's life. One must trust even in the face of one's own feelings (cf. Proverbs 3:5-6). Cultivate the habit of depending on God constantly for strength (cf. Jantz & McMurray, 2003:139, 140).

If one's faith is weak, ask God to give one specific faith for healing. Healing is a distinctive gift from God. One cannot make oneself belief, nor can one force faith. True faith is founded on the Word of God and is made alive to one by the Spirit of God (cf. Smith, 2005:105; 4.3.2). Ask God for specific faith for one's healing. A faith full of trust, believing without doubting, is the kind of faith God is seeking to find in one.

Praxis II application will lead to inner peace and one will experience unbelievable joy (Philippians 4:4-13).

5.3.8 Making healthy choices

One of the key premises of the model is that counselees have to make choices when dealing with sin, the emotional consequences of chronic or terminal illnesses, and/or emotional circumstances pertaining to their depression. The most important choice is to accept and receive Christ as one's strength. Lifelong happiness is a choice (cf. table 4.2). Furthermore, determining to obey God is a life saving choice (cf. Minirth & Meier, 2002:197).

To maintain control over one's emotions, one has to assume responsibility for one's thoughts. One does have the capacity to choose what one is going to do with information causing distress, and by *choosing the truth* one will manage one's emotional response to the information.

The following flow chart can be used by the counselee to assist him/her in making healthy choices:

Making healthy choices

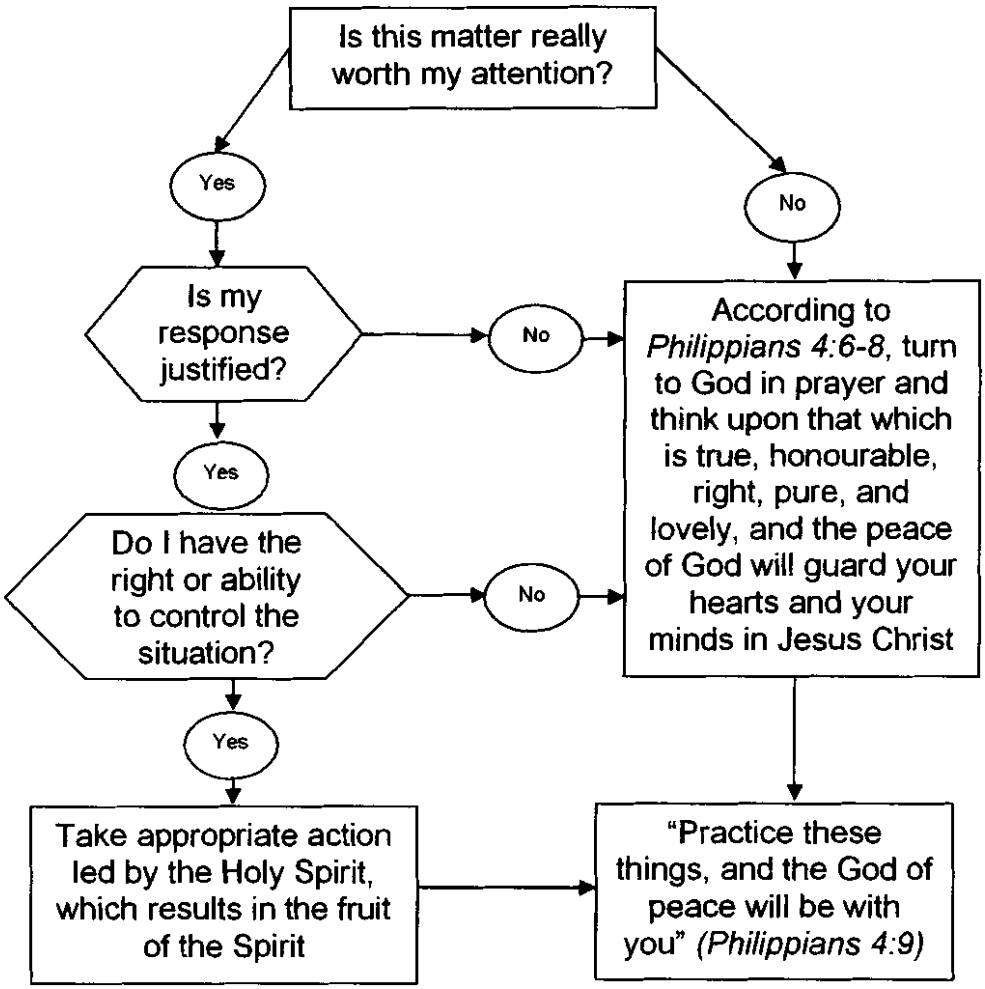


Figure 5.7

5.3.9 Pocket-size reference guide

The counselees are provided with the following pocket-size reference guide with helpful tips to remind them on a daily basis how they should live to become more Christ-like and find everlasting peace:

Pocket-size reference guide

Spiritual	Medical	Psychological/ Circumstances
• *Develop a relationship with God* (2 Chronicles 16:9a; Psalm 42:1; Psalm 73:25-26; Isaiah 26:3; Matthew 23:37; Romans 8:15; Romans 8:32). • *Pray continuously* (1 Chronicles 4:10; Psalm 55:17; Psalm 91:15; Luke 18:1; **Philippians 4:6**; James 5:17). • *Study and meditate on God's Word* **2 Corinthians 1:3-11** and **Philippians 4:4-13**. • *Put your hope and trust in God* (Genesis 18:14a; Numbers 23:19; Psalms 23:1-3a; Psalm 27:13-14; Psalm 37:23-24; Psalm 40:2; Isaiah 40:28-31; Isaiah 43:1-2; Isaiah 58:11; Jeremiah 29:11; Lamentations 3:21-22; Ezekiel 36:9; Nahum 1:7; Zechariah 4:6b; Romans 7:24;	• Take antidepressants as prescribed. • Monitor use of medication with the help of a physician or psychiatrist. • Get adequate exercise. • Get adequate sleep. • Eat nutritious meals. • Join a relaxation class and/or go for regular massages. • In case of an emergency call: *Insert number*	• Live one day at a time. • Meditate on positive thoughts. • Use positive self-talk. • Divert attention from self to others. • Listen to Christian music. • Do what one can to deal with the fear or problem causing the anxiety – examine different alternatives or possible solutions and try one. • Talk with a close friend at least once a week about one's frustrations. • Get adequate recreation. • Do not procrastinate – putting things off causes more anxiety. • Set a time limit on one's worries. • Join a support group.

Spiritual	Medical	Psychological/ Circumstances
1 Corinthians 10:13; **Philippians 4:13**; 1 Peter 5:7). • *Rejoice in the Lord* (**Philippians 4:4**). • *Avoid Satan and sin* (Luke 22:31-32; Ephesians 6:10-12; Hebrews 11:24-26; James 4:7-8; 1 Peter 2:11; 1 John 2:15-16). • *Build a support group* (Psalm 18:16; Proverbs 17:17; Proverbs 18:22; Proverbs 27:17; Ecclesiastes 4:9-10; **2 Corinthians 1:3-4**; 2 Corinthians 7:6; Philippians 2:4; Hebrews 6:10; Hebrews 10:24-25).		

Table 5.4

5.4 PRELIMINARY CONCLUSIONS TO CHAPTER FIVE

For many people with depressive or anxiety disorders there are a number of psychological issues that need to be addressed.

Without the proper biological treatment, psychotherapy can be a fruitless and frustrating experience for both the therapist and the patient. This is not to say that psychotherapy is not a necessary component of treatment, but it often needs to be done in combination with the right biological treatment. It is

believed that bio-medical and psychosocial approaches need to be combined with Christian counselling in treating depressed or anxious clients.

The shortcoming of the psychosocial and other models is that it does not focus sufficiently on the importance of faith in sustaining healing or inner peace. Once the counsellor has finished the counselling it is important that the counselee is adequately equipped to deal with potential recurring depression or anxiety spells. Regular prayer, studying of Scriptures, involvement in a faith-community, filling of the mind with positive thoughts (cf. Philippians 4:8) and biblically-based choices are critical for achieving and sustaining healing and/or inner peace.

Every counsellor has a theology – along with a spirituality, biomedical theory, psycho-social theory – that directly influences the counselling process. Religious beliefs provide a worldview that is positive, coherent, optimistic, and caring. Religion gives purpose and meaning which is particularly true for people undergoing negative life experiences or difficult situations – and that includes those with mental or emotional problems. Unfortunately Christian counselling is largely deficient in its theological roots and spiritual practices.

The following therapeutic approach is put forward for mood and anxiety disorders as a proposed practical framework within which the holistic faith-based therapy can be applied:

- Conduct the initial assessment:
    - Explore presenting problems.
    - Diagnose, in collaboration with a psychiatrist or psychologist, using a DSM-IV multiaxial assessment and other psychosocial rating scales.
- Develop an individual treatment plan (choose appropriate interventions).
- Describe the holistic faith-based treatment approach.
- Implement the treatment plan.
- A final imperative for concluding the treatment includes a session devoted solely to reinforcing the importance of *faith* in ensuring

lasting healing and/or peace, or coping with the mood- and anxiety disorder. The counselees are provided with a pocket-size reference guide with helpful tips to remind them on a daily basis how they should live to become more Christ-like and find everlasting peace.

One of the precipitating factors of depression is sin. One of the significant departures of psychopathological models is that almost none take sin seriously as a possible cause of illness. One's personal responsibility is rarely emphasised in current psychological thinking. Even less often is individual accountability before God taken into account. This is in contradiction with the Christian worldview.

Possible sin-related causes of depression include negative attitudes like bitterness and hatred, guilt and lack of repentance over sinful behaviour or attitudes, turning away from God and His Word, fear of the future and lack of trust in God as sufficient provider, and unbelief in general. Christ desires that one **confesses one's sin**.

If from the diagnostic analysis it is believed that the depression of the counselee is caused by a **medical condition**, the counselee is referred to a medical practitioner for confirmation of the illness and the necessary medical treatment. The premise of this model is that this is not sufficient by itself and that the counselee will benefit greatly from follow-up Christian counselling.

It is important that the counselee understand that all people can get depressed and that God can heal them not only from their illness but can also provide relief from their depression.

The counselee should be made aware of the fact that medication is necessary if chemical imbalances exist, that they should not have any guilt feelings about their illness and that God has given scientists the expertise to discover medical interventions.

CHAPTER SIX

FINAL CONCLUSIONS AND SUGGESTED FURTHER RESEARCH

6.1 FINAL CONCLUSIONS

The **central theoretical argument** of this study is that faith can heal or help counselees to cope with mood and anxiety disorders.

The **aim** of this study was to research how the healing power of faith can be utilised by counselees to understand, manage and overcome mood and anxiety disorders.

The **objectives** of this study were:

- To study the viewpoints of the scientific disciplines of psychiatry, psychology and medicine regarding depression and anxiety and the role these play in people's lives and how these conditions are treated.
- To examine how the selected group experience depression and respond to faith-based counselling by means of qualitative structured interviews.
- To explore what the Bible has to teach about "depression" and faith and to research its revelation-historical stance on this.
- To examine the answers offered to depression sufferers in holding on to faith by studying scriptural examples related to "depression", such as Lamentations, and of the harmful role that "depression" played in the lives of key biblical figures (such as Moses, Job, Elijah, David and Jeremiah), and to establish how they dealt with the "depression".

- To propose an integrative model which can be used by pastoral counsellors for dealing with depression in a faith-based context and for equipping depression sufferers to constructively deal with their depression and anxiety.

These objectives were accomplished and below, the conclusions pertaining to this study, namely the development of a holistic faith-based model for biblical counselling of depression and anxiety sufferers, are explained and suggestions are made for further research.

In **chapter 2 (meta-theoretical perspective)** it was shown that depression and co-morbid anxiety have become the most prevalent mental health issues in today's world. Most people suffering from these disorders do not receive the appropriate treatment. Treatment is generally incomplete and does not consider the interrelatedness of body, soul and spirit. Treating these disorders is complex and requires a thorough understanding of the causes of the disorders and the necessity of a holistic approach to healing (cf. 2.3.3; 2.3.5; 2.3.8).

In the world of mental health care, the overarching term being mood and anxiety disorders, *anxiety* and *depression* are regarded as two distinct disorders. However, many people suffer from both conditions. In fact, most *mood disorders* present as a combination of anxiety and depression. It can be disabling physically, mentally, emotionally, and spiritually, making even the most successful, productive and creative people feel worthless (cf. 2.2; 2.3; 2.6).

Depression begins and grows out of a complex interplay between the body (biological factors), the mind (the way one thinks and looks at things), one's habits (one's personality style and patterns one has developed for coping with people and life's stresses), interpersonal factors (one's relationships with others, past and present), and spiritual problems (sinful responses, faulty teaching or

understanding regarding God and his character, and a loss of purpose or meaning to life; cf. 2.3.2.1; 2.3.3; 4.3).

Research shows that depression seems to be getting worse. People born during the past three decades are three to ten times more likely to become *depressed* than those born in previous generations. Not only is depression on the rise; some researchers feel that people are becoming depressed at earlier stages than in previous generations (cf. 2.3.5; 4.2).

Without treatment depressions recur in 50% of cases, and after three or more episodes, the odds of recurrence increase to more than 70%. Individuals with severe depression and bipolar disorder have a high risk for suicide. The suicide rate has also been on a shocking increase in recent years. This escalating death rate has occurred in spite of the billions of antidepressant drugs and tranquilisers that have been dispensed during the past several decades (cf. 2.3.2.1; 2.6).

Depression is a mood in which a person feels extreme sadness, withdraws socially, feels guilty and expresses self-deprecating thoughts. Depression is a complex condition to handle or cope with. Depression is not unitary or homogeneous. It is actually heterogeneous and refers to *different* types or kinds of depression with different risk factors involved. Some people are more at risk for depression than others. Understanding depression is the first step toward effective coping (cf. 2.2; 2.3.1; 4.2).

There are a number of possible causes of depression and various authors emphasise different causes, depending on their theoretical viewpoints and models of depression. Psychoanalytical theories see mood disorders as anger turned inward. Behaviourists view depression as a group of learned responses, whereas social theorists consider depression the result of faulty social interactions. Medical practitioners believe there is a *biological bases* for mood disorders. Like most other mental illnesses, mood disorders reflect the altered

functioning of many parts of the brain at the same time. Satan and God may also cause suffering. Depression might have a physical cause, but it may simultaneously be the consequence of spiritual warfare, the sin of other people, and one's own sin (cf. 2.3.3; 4.3).

Anxiety can be defined as an emotion associated with some type of internal or external threat to physical or emotional well-being. It is accompanied by a sense of fear or worry about the future, whether in response to a distinct event, or to no event in particular. It may include feelings of physical restlessness and tremulousness. Experts believe that anxiety disorders are caused by a combination of *biological* and *environmental* factors. The mechanisms in the body, which regulate the amount of stress and the times one feels it, play a large role in the anxiety illnesses (cf. 2.4.1; 2.4.2).

Most people experience a certain amount of anxiety and fear in their lifetimes and it is a normal part of living. For millions, however, anxieties and fear are persistent and overwhelming, and can interfere with daily life. Anxiety disorders are the most common psychiatric illnesses affecting both children and adults (cf. 2.4; 4.3).

Anxiety disorders are generally classified as follows: Panic Disorders, Obsessive Compulsive Disorder, Post-traumatic Stress Disorder, Generalized Anxiety Disorder and Phobias (cf. 2.4.3).

The vast majority of people with an anxiety disorder can be helped with the right professional care. The treatments that work best for depression also combat anxiety. A number of highly effective treatments for depression are available, although they present many treatment challenges (cf. 2.3.8; 2.4.6; 4.2). Treatments include:

- Psychotherapies.
- Electroconvulsive therapy.
- Drug therapies. There is broad agreement that antidepressant medication can make some people feel better.

Chapters 3 and 4 (basis-theoretical perspectives) focused on the biblical viewpoints of "depression", faith and healing. The Bible does not use the words *mood* and *anxiety disorder* or *depression*, although it describes people whom might be suffering from it. Great men of God have been known to suffer "depression". The Bible tells of kings and prophets who became depressed. King David, Moses, Job, Elijah and Jeremiah are good examples of this. They frequently developed health issues and expressed anger with God. Yet, God spoke to them, like many other biblical figures, not because they had special abilities, but because they were willing to listen to Him (cf. 2.3.5; 3.3.1; 4.3). The key lessons learned from the emotional experiences of the selected biblical figures are (cf. 3.3.4):

- One should learn how to hear God's voice and obey his Word.
- Depression sufferers can find hope and comfort by *opening up their hearts and minds to God.*
- People who struggles with depression is encouraged to work on strengthening their *relationship with God*, even when God feels far removed from them.
- Depression sufferers can find great reassurance through *regular daily prayer.*
- Focus on God rather than one's *situation. God is greater than circumstances* One should learn how to react correctly.
- God will aid the depression sufferer in *every* way – in contravention to the common belief among depressives that God is angry with or does not care about the depressed sufferer.
- Good mental health cannot totally be separated from one's physical health, which must be maintained with *good nutrition, exercise, and rest.* This is especially important for the person struggling with depression.
- Depend on *God's love* as one develops endurance.

God created people with emotions and He shared with them the full range of human emotions. The capacity to feel and express emotions is a wonderful gift from God. Emotions play an important role in people's lives. Body sensations, emotions, and feelings should be understood for their primary spiritual function. The principal function of emotions, feelings and body sensations is to give people internal feedback as to whether or not they are acting in keeping with God's laws, values, and goals (cf. 3.3.1).

Both psychology and the Scriptures point to the fact that depression and anxiety can be either normal or abnormal. Depression and anxiety may be the antithesis of faith. Considering the fact that God created man and gave people emotions, it can be concluded that sin is the cause of unhealthy or out of control emotions. The effect of sin must be dealt with in order for emotional *healing* to occur. Depression and anxiety are not necessarily signs of spiritual failure. In the Scripture stories, some of the greatest depressions came as emotional letdowns following the greatest spiritual successes (cf. 2.3.3; 3.3.1).

When mood and anxiety disorders are caused by sin it is important to confess the sin. When sin is left unconfessed, a wall goes up between a person and God. Satan is devastatingly effective in using the weapons of guilt, rejection, fear, embarrassment, grief, depression, loneliness and misunderstanding (cf. 3.3.1; 3.3.2; 4.5).

There is evidence in nature and in Scripture that God is not opposed to the use of medicine, and he created some plants to be used specifically for medicinal purposes. The right medicine can be extremely helpful when one's physical, emotional, and mental state are deteriorating and one is losing one's ability to function. Without the proper biological treatment, psychotherapy can be a fruitless and frustrating experience for both the therapist and the patient. This is not to say that psychotherapy is not a necessary component of treatment, but it

often needs to be done in combination with the right biological treatment (cf. 2.3.8).

However, medication does not always work for some people, or its effectiveness diminishes over time. Individual therapy is often as effective as medication and sometimes more so in helping a depressed person recover (cf. 2.4.6).

The author is of the opinion that health must be addressed holistically - physically, mentally, emotionally, socially, environmentally, and above all *spiritually*. Through the years, the scientific studies linking the emotions and disease have produced an impressive body of research, all of which points to the conclusion that *what* one feels as emotions results in *how* one feels physically, emotionally and spiritually. Modern medical research is proving the positive relationship between health and godliness. Religious commitment was shown to counteract the hopelessness and despair of depression. However, people have separated church and state, medicine and spirituality, healing and faith (cf. 3.2; 4.2; 4.5).

It is believed that bio-medical and psychosocial approaches need to be combined with Christian counselling in treating depressed or anxious clients. Regular prayer, studying of Scriptures, involvement in a faith-community, filling of the mind with positive thoughts and biblically-based choices are critical for achieving and sustaining healing and/or inner peace. The shortcoming of the psychosocial and other models is that it does not focus sufficiently on the importance of faith in sustaining healing or inner peace. Once the counsellor has finished the counselling it is important that the counselee is adequately equipped to deal with potential recurring depression or anxiety spells (cf. 3.3.3; 4.4).

It does not make any difference whether the precipitating cause of depression is physical, mental or spiritual. Depression and anxiety affects the *whole* person, and a complete cure requires a holistic answer. Depression is related to a

person's *physical health*, what they *believe*, how they *perceive* themselves, their *relationship with God*, their *relationship with others*, the *circumstances* of life, and finally, it may have something to do with *Satan*. One cannot successfully treat depression without taking into account all related factors (cf. 3.2).

Spiritual health is therefore absolutely necessary for all people to have psychological health. From this, one can conclude that a deep knowledge and understanding of the Word of God and growth in spiritual matters are required to deal with one's depression because depression has an insidious way of draining energy, twisting values, and assaulting faith (cf. 3.2; 4.4).

Faith in God is the foundation for emotional control, restoration and healing. It takes both deep personal faith in God and an active involvement in a faith community for people to obtain maximum health benefits. If people include religion in their lives from a sincere sense of faith, better mental and physical health may naturally follow. Faith is learning to depend absolutely on God and His Word, regardless of one's circumstances; meaning that one's faith will remain firm because it is focused on and fastened to a living God (cf. 4.4).

The word that's commonly translated *faith* in the Bible means more than mere *belief*. It does mean belief, but it also implies dependence and trust. Faith, because it incorporates dependence and trust, also embodies *action*. This action can take many forms, but belief that does not eventuate in a changed life is not true biblical faith (cf. 3.3.2; 3.5).

Faith involves a kind of positive thinking that by itself *heals* and prepares the body for *healing*. Anxiety is most of the time overcome by *faith* in God, and *spiritual attacks* are overcome by worshipping God in one's daily life. Faith is actually a source of comfort and consolation, provided that it is active and alive (cf. 3.2; 4.2).

Faith sees God as He is. Faith believes what God can do. Faith anticipates what God will do. Faith believes God has the power. Faith is *belief based on facts*. However, faith is more than recognition of facts. A person may know all about Christ as revealed in the Bible, may even believe God's Word to be true, and yet not have real faith in Christ as his personal saviour. Agreement by the mind is not the same as surrender of the heart (cf. 3.3.2).

Faith needs strengthening, because it constantly faces attacks by one's sinful nature and the entire evil world. The Lord strengthens faith in different ways (for example through testing and his guidance of one's entire life). God allows Satan to tempt people to test their *faith* (cf. 3.3.2).

The Bible is full of accounts of *healing*; particularly the Gospels. Jesus, Paul, and the rest of the early church lived in regular expectation that God would heal people's physical bodies. According to all four canonical Gospels, Jesus Christ devoted a considerable part of his ministry to performing *miracles* of *healing* for a wide variety of people. Jesus Christ only performs His miracles where there is faith. These miracles sometimes occurred in response to *faith* and sometimes to instil *faith*. Faith in itself has no inherent power to cure anybody. Faith is an important component for healing, but it is always *faith in God* (cf. 3.3.3).

One needs to recognise that Jesus Christ is able to heal through the Holy Spirit who lives in one (1 Corinthians 6:19). However, if one is faithful, and has prayed, one has to trust God that He knows what He is doing, if He leaves one unhealed. Christ does not always take away the pain, but He does tell people to bring it to Him. Healing is a *gift* and not necessarily a *right*. Deeper than asking for healing, then, lies the dependence on, and trust in God (cf. 3.3.3).

Inner healing is part of Jesus Christ's redemptive work in one's spirit and soul and *inner healing* ministry seeks to deal with inner emotional pain. Jesus Christ shows in His healing ministry that *inner healing* is a vital part of the process of

becoming healthy. His compassionate response to those in need demonstrates that true *healing* is bringing *wholeness* not only to one's body but also to one's emotions and inner being (cf. 4.5).

Based on an exposition of 2 Corinthians 1:3-11, it can be concluded that God is the Father of mercies, and God of all comfort. If people are afflicted, it is for their good, or if they are comforted, it is for their good. The word "comfort" may denote *emotional relief* and a sense of *well-being*, *physical ease*, *satisfaction*, and *freedom from pain and anxiety*. Those who share mutual suffering and affliction share also in the joy of consolation. For people in despair prayer is powerful because God listens, responds and delivers. Deliverance comes through *intercessory prayer* (cf. 3.4.1).

Based on the exposition of Philippians 4:4-13, it can be concluded that if one is to enjoy the power of God at work in one's inner being, then one must model one's relationship on Christ, surround one's circumstances by prayer, drill one's mind in godly thinking, and subject one's life to the Word of God. Prayer is how one maintains contact and focus on Christ. One taps into the peace of God through prayer. Peace is the product of prayer. Peace will guard one's heart and mind. It does not mean one will receive everything one asks for, but simply that there will be peace (cf. 3.4.2).

Scientific research is now validating the power of *prayer* in healing and recovery. The benefits of the power of prayer and meditation are more profound than the calming effect on the body, mind and emotions (cf. 2.4.6; 4.4).

In **chapter five** the key results derived from the meta-theoretical perspectives (psychology and medicine, as discussed in chapter 2), basis-theoretical perspectives (expository approach, as discussed in chapter 3), and the basis-theoretical perspectives ("popular theological" approaches, as discussed in

chapter 4) to depression and anxiety have been used as a basis for developing a holistic faith-based model for treating depression sufferers.

Every counsellor has a theology – along with a spirituality, bio-medical theory, psycho-social theory – that directly influences the counselling process. Religious beliefs provide a worldview that is positive, coherent, optimistic, and caring. Religion gives purpose and meaning which is particularly true for people undergoing negative life experiences or difficult situations – and that includes those with mental or emotional problems. Unfortunately, Christian counselling is often deficient in its theological roots and spiritual practices (cf. 5.3.4).

In the **practice-theoretical perspective** the following therapeutic approach is put forward for mood and anxiety disorders as a proposed practical framework within which the holistic faith-based therapy can be applied (cf. 5.3.4):

- Conduct the initial assessment.
    - Explore presenting problems.
    - Diagnose, in collaboration with a psychiatrist or psychologist, using a DSM-IV multiaxial assessment and other psychosocial rating scales.
- Develop an individual treatment plan (choose appropriate interventions).
- Describe the holistic faith-based treatment approach.
- Implement the treatment plan.
- A final imperative for concluding the treatment includes a session devoted solely to reinforcing the importance of *faith* in ensuring lasting healing and/or peace, or coping with the mood and anxiety disorder. The counselees are provided with a pocket-size reference guide with helpful tips to remind them on a daily basis how they should live to become more Christ-like and find everlasting peace.

One of the precipitating factors of depression is sin. One of the significant departures of psychopathological models is that almost none take sin seriously as a possible cause of illness. Rarely in current psychological thinking is one's personal responsibility emphasised. Even less often is individual accountability before God taken into account. This is in contradiction with the Christian worldview (cf. 5.3.5).

Possible sin-related causes of depression include negative attitudes like bitterness and hatred, guilt and lack of repentance over sinful behaviour or attitudes, turning away from God and His Word, fear of the future and lack of trust in God as sufficient provider, and unbelief in general. Christ desires that one **confesses one's sin** (cf. 5.3.5).

If from the diagnostic analysis it is believed that the depression of the counselee is caused by a **medical condition**, the counselee is referred to a medical practitioner for confirmation of the illness and the necessary medical treatment. The premise of this model is that this is not sufficient by itself and that the counselee will benefit greatly from follow-up Christian counselling (cf. 5.3.5).

It is important that the counselee understand that all people can get depressed and that God can not only heal them from their illness but can also provide relief from their depression.

The counselee should be made aware of the fact that medication is necessary if chemical imbalances exist, that they should not have any guilt feelings about their illness and that God has given scientists the expertise to discover medical interventions.

There are wide-ranging external circumstances that can lead to depression. The underlying circumstance/s causing the depression should be identified and analysed. The counsellor should then prepare a **plan of action** (cf. 5.3.5).

Depending on the underlying circumstances the counselee can be counselled using different psychosocial approaches and biblical truths. Examples from the Bible of people that encountered similar circumstances can be used to illustrate how these people handled their depression. The best insights can be obtained by studying the faith-filled and faith-driven life of Jesus Christ (as explained in appendix B).

Irrespective of the root cause/s for the depression, the next phase of the model is to lay the foundation for the application of new learning and practice, which includes (cf. 5.3.6):

- Development of an ongoing relationship with the God of hope.
- Focusing on Christ and God's Word.
- Trusting God and growing in faith.

One of the key premises of the model is that counselees have to make choices when dealing with sin, the emotional consequences of chronic or terminal illnesses, and/or emotional circumstances pertaining to their depression. Lifelong happiness is a choice and determining to obey God is a life saving choice (cf. 5.3.8).

To maintain control over one's emotions, one has to assume responsibility for one's thoughts. One does have the capacity to choose what one is going to do with information causing distress, and by *choosing the truth* one will manage one's emotional response to the information (cf. 5.3.8).

Healing of emotional wounds is a process, not something that is achieved overnight by a crisis experience. It requires an investment of time and diligent obedience to God's commands. Fruit always matures and ripens slowly.