DEPRESSION EVENT Q & A

In November, the O's sponsored a church-wide event on depression. Many who came had questions—more than our panelists had time to answer. Here are a few of the questions and the responses of our panelists, family counselor David Wood, and Dr. Rosalind Goodrich, our guest speaker.

DISCLAIMER: Answers contained herein are for information and education only. They are not therapy, nor should they be considered any form of treatment. Accurate diagnosis and treatment requires more complete interaction with a professional. For further information, consult a medical or psychological clinician.

QUESTION: *My family has caused me anxiety since I was a child. I feel better away from them even though I can be around them for short periods of time. I have always found my emotional wellness from non-family. I feel guilty and wonder if I am disobedient to God because it is hard to do things concerning family to help them because it is so stressful.*

> **David Wood**: It is important to recognize WHY one is anxious. If it is due to specific trauma, it should be handled differently than if it were a more vague sense of discomfort. If it is due to conflicting values or worldview, it may be beneficial to take family in "small doses" to avoid unpleasant and unproductive verbal exchanges. It may help to prepare before family encounters and be ready to respectfully bow out when one has reached one's limits, that is, when one begins to struggle to maintain one's own composure. Remain close to God in the desire to love as He does, and depend on His strength and timing.
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> **Rosalind Goodrich**: It is worth considering that many times Christians—because they want to do the right thing!—are conscientious. This is generally a good characteristic and practice--work, relationships, etc., tend to run well when everyone is trying to be responsible. It is valid and important for us to examine our behavior and thoughts—but it can make it more difficult if we take on additional anxiety or guilt about what we should be doing when we are already struggling. It is already challenging to cope with anxiety or strained relationships; when we feel bad because we think we are at fault, that can make it harder. Because our world isn't yet made perfect, not every person will be able to interact in a harmonious way. Of course we'd prefer to have deep, spiritually and emotionally heathy relationships with our family, and, generally, we want to work for that. But it is OK in situations where family difficulties are intractable to share deep relationships with friends and fellow Christians if our family is unwilling or unable to build those kinds of relationships.

QUESTION: *What is the best way to support a loved one who has severe depression and anxiety, who is on two prescribed meds for it, and they still need verbal prompts to take care of their daily self care? This loved one rarely leaves the house unless going somewhere with me, talks down on self, says nothing they do is good, and has said that I'm the only reason they haven't taken their own life and that if anything ever happened to me they'd have nothing left to live for.*

> **David Wood**: Caregiver burnout is a real thing. You must monitor yourself and accept some practical limitations to your abilities to influence your loved one. An audible timing device (watch or phone alarm) could assist one as a reminder to take medicine. Bringing them to social events or to church, where they may have more exposure to others, and also employing other loved

ones to visit can broaden the opportunity for interests to develop outside the darker corners of the depressed mind, as well as offer help in monitoring the patient's mood. Sharing books or information regarding how to manage depression, and perhaps volunteering with them in service to others (such as helping at a mission) could open up their world. Should suicide become more of a concern, one should be prepared to call 911. Meanwhile, increasing one's knowledge and confidence by education through many of the resources available online (e.g., google: "suicide prevention"). One may not always be able to act as a social director, but one may call to remind them that they are cared for.

Rosalind Goodrich: Certainly this is a challenging situation. We do the best that we can to care for others, yet there are some limitations to what we can do for our loved ones—we can't control their thoughts, emotions, and behavior, even when we try to encourage and support them. Some caregiver support in this situation sounds like a good idea to me. If current treatment isn't working, it may be helpful to look into additional options. Sometimes local community clinics will provide in-home therapy for situations in which traditional counseling in the office doesn't seem to be helping. If traditional therapy isn't working, looking at family counseling or even behavior analysis might be another option. It is easy for both the person who has depression and an involved caregiver to become isolated, which typically isn't helpful; even when social activities don't immediately feel like they are helping, social and community connection do seem to make a difference.

QUESTION: *How to respond in a healthy way to those in our lives who struggle with depression? Where are the boundary lines that will help the person (not hinder their recovery nor fall into codependency) when a loved one or family member has depression/mental illness that has resulted in years of dysfunctional behavior?*

David Wood: There is unfortunately no easy answer to your question, as there are potentially too many variables (type of depression, personalities involved, exhibited behaviors, etc.) There are some excellent books (online see christianbook, Amazon) on the topic of boundaries which can give one a start. Beyond that, individual or family therapy may help to keep communication open as boundaries may need to be adjusted or redrawn. Discussing honestly both your love, concerns and hopes, and praying with and for them if they are willing can provide an atmosphere of support. Creating a caring team with others can provide relief, insight, and balance.

Rosalind Goodrich: Yes to all David said! Self-care and support for the family member(s) is important, including seeking input from the mental health community.

QUESTION: What causes people to make so many wrong choices that they continually sabotage their life . . . also risky behavior with an attitude or belief that "I won't get caught"?

David Wood: There is no singular underlying cause likely to produce such behaviors. The experiences, coping mechanisms, and personality traits one has all play a part in how we perceive and respond to life circumstances. There is additional evidence that some behavioral aspects have a genetic component which may predispose a tendency toward some behaviors. Often there is some unexpressed or shared pain which can drive self-destructive behavior. Even chemical imbalances, such as are found in bipolar depression, can influence one's ability to cope well with life. There is much help available to those who are hurting and confused (for example,

Celebrate Recovery) and promoting a spiritually founded, supportive environment can greatly assist those who are willing.

Rosalind Goodrich: Most behavior is complex; even people in the same situation may experience it and think about it differently—so they are affected differently. That's part of the reason that pursuing the Lord first, and then health in other areas in addition to spiritual—relational, cognitive, behavioral—is important and helpful.

QUESTION: *Can depression cause a person to have a critical attitude toward people?*

David Wood: Yes, but so can many other factors. Was the person critical before the depression was manifest? Are there other stressors at work in the person's mind (i.e., negative experiences dominating, chronic pain, grief, feelings of threat or embarrassment)? Being a good listener may provide some clearer clues.

Rosalind Goodrich: Depression sometimes looks like irritation and anger rather than sadness and despondency. Looking at the whole context is important.

QUESTION*:* *Is depression more prevalent in people with anxiety? How do drugs like alcohol, meth, contribute to depression?*

David Wood: There appears to be some overlapping of several of the symptoms for each disorder, and those with a diagnosed anxiety disorder are "more likely . . . to meet criteria for other . . . depressive disorders" (from the DSM 5 manual; used to formally qualify diagnoses). Coping mechanisms can mask or temporarily alleviate one's experience of the negative feelings associated with such disorders. Unfortunately, some come at a high cost to other aspects of health and relationships. In attempts to manage the symptoms, the source(s) of the anxiety/depression can be overlooked. It is important to seek professional (pastoral and/or therapeutic) help when substance abuse is involved, as support is often needed to overcome the temptation of a "quick fix." Group support/therapy has also been helpful to many.

Rosalind Goodrich: Agree!

QUESTION: *I can tick nearly every causal box from childhood trauma through chronic pain. Coping skills have been a major weakness for me all my life. Without insurance/money, how do I learn these skills late in life?*

David Wood: Helpful attitudes to cultivate include being patient with oneself, and learning from one's mistakes rather than punishing oneself. A trusted mentor or friend can help one gain and maintain a balanced perspective in one's thinking, and helps to remind oneself of God's timing, companionship, and grace. Do not isolate. Keep moving, even if it's an inch at a time. Monitoring one's self-talk, and resolving to treat oneself as one would a trusted friend (with compassion, not condemnation) can be helpful. Staying focused primarily on the present and repeatedly reminding oneself of the things—big and small—for which one is grateful can shift one's perceptions. By knowing and accepting that one has purpose in God's creation, one can search out, discover, and apply one's passion(s) about living.

Rosalind Goodrich: Amen! Self-compassion is important. While not all of them "click" for everyone, there are good self-help books that you can read in the areas of cognitive behavioral therapy and dialectical behavioral therapy, and other approaches that can help you build coping skills. You may find other good, free resources through Christian—and secular (evaluate if it is the right "fit")—professional organizations. I agree so much with the idea of continuing to move forward. You might approach learning coping skills a bit like an experiment—if one thing doesn't work, try another; you'll be learning along the way. Celebrate Recovery or other groups may be worth exploring.

QUESTION: *Can untreated adult ADD with cognitive dysfunction cause depression?*

David Wood: There appears to be some consensus that adults with ADD are more likely to battle symptoms of depression as well compared to the general population. While there seems to be this correlation, there is yet no conclusion that ADD causes depression (though it makes sense that the struggle with ADD could negatively affect the bearer's sense of identity and self-worth, especially in adolescents).

Rosalind Goodrich: Agree. If you seem to be struggling with both, you may want to seek input from a mental health provider to work with you on how to address both.

QUESTION: *What steps can be taken to reconcile family relationships with members who have mental and clinical depression?*

David Wood: A good start may be to confirm with one another the "elephant in the room"—that depression is a thing, but it need not grow in the shadows to overwhelm all of one's joy in life. Encourage one another to speak the truth (from each one's perspective) in love, and hopefully get all involved to commit to resisting/overcoming its influence. Educate yourselves about depression through trusted sources (e.g., Christianity Today, Focus on the Family) articles and books. Collaborate with professionals (pastoral and/or therapeutic) for guidance, wisdom, and perspective. Discuss options of specific actions which are likely to help, and be willing to experiment to discover the best in your case.

Rosalind Goodrich: Trying to listen to understand is generally helpful in almost all relationships. Try to resist blame—on family members and on yourself! Many times people are struggling because of a number of complex factors. Remember that connecting and rebuilding relationships can take time, and that it is OK if it does.

QUESTION*: At a young age I was physically and sexually abused by my biological father. I have forgiven him and made amends before he recently died. Just found out I have 20% short-term/long-term memory loss. Does this give me greater than normal chances for clinical depression, which I have?*

David Wood: t seems less likely that the memory loss itself would be the sole source of one's depression. However, any significant loss (i.e., of one's innocence, precious memories) could produce grief, which can have similar symptoms, and which can co-occur with clinical depression. Memory loss can be a form of self protection from trauma. Barring a physical cause, such as traumatic brain injury, some experiences are repressed in order to survive and cope with the rest of life. Memory loss, especially short-term, can be frustrating and challenging to one's self image,

and it is important to focus on what one has rather than worry about what one has lost. Current brain research points to an increased understanding in the resilience and potentially reparative aspects of brain cells. The exact mechanism of memory loss and depression co-occurrence is not clear with long-term memory, although there is a relationship between the symptoms of clinical depression and short-term memory. One's emotional and mental state (i.e., high stress level, feelings of being overwhelmed, etc.) can affect one's short-term memory, cloud one's thinking process, and make tasks more difficult. Some symptoms such as memory loss are also associated with PTSD. It is important to seek a clear diagnosis from a professional to formulate the best course of action.

Rosalind Goodrich: Agree.

QUESTION*: How do you encourage/instruct patients when they can't take SSRIs or other mood-altering meds?*

David Wood: Other avenues with potential to affect symptoms include nutrition, exercise, social engagement, spiritual development, holistic approaches, hypnosis, interpersonal and cognitive-behavioral therapies. Maintaining basics of health by eating well, exercising regularly, and getting adequate sleep are important. Monitoring one's moods and activities/life events through a calendar, log, or journal can be helpful to target influences and patterns affecting mood. Meditation and music listening, engaging in a new hobby, volunteering are options to consider as well. A willingness to experiment and to develop social support can provide encouragement to try new things. A willingness to try not just once, but to give a new activity a reasonable time to prove itself useful can provide a more accurate assessment of its benefits.

Rosalind Goodrich: Yes. These are all really good avenues, and all of them have been shown to be helpful. If one can't take meds, it is important to remember that there may need to be a combination of approaches to help reduce depressions symptoms. It is worth putting the time into spiritual, social, cognitive, physical, etc. health care even if it takes some time.

QUESTION: *Is clinical depression the same as major depression? If not, how are they different? Are these considered a lifetime diagnosis?*

David Wood: There are several kinds of depression, as were highlighted at the O's presentation. Each has specific symptom criteria to qualify it as a particular type, including severity and duration of symptoms. When the criteria are met, it is deemed a type of "clinical" depression with a specific title, e.g., "Major Depressive Disorder," "Persistent Depressive Disorder," etc. In more common usage by non-professionals, the terms of "clinical" and "major" may overlap, but the clinical definitions are more specifically defined. A diagnosis is intended to define a current condition, not necessarily to predict a permanent state. A prognosis conveys the expected course of a disease in the future. There is still much to be understood about the dynamics and sources of depression as there are many variables and interactions among them to be considered. Some diseases tend to be more chronic than others, but meanwhile there is much that can be done to alleviate a great deal of the suffering from various types of depression.

Rosalind Goodrich: For many people, depression can be temporary; it does not mean that you will have it chronically and lifelong. There are people who have a greater, more long-term struggle, but many people have depression for a relatively short time and recover well.

QUESTION: *Is it possible for medications to completely alleviate symptoms? I'm takin an antidepressant . . . it definitely helps, but there are still lingering feelings/symptoms under the surface.*

David Wood: The general consensus among professionals is that a combination of talk therapy and use of medications is more effective in treating major depression than either used alone in most cases. That is not to say that there aren't those who find sufficient benefits from one or the other alone—just that they are likely to be more rare. Tracking one's mood using a journal or calendar can provide a clearer relationship to life events and mood. Regular visits with one's prescriber allows the optimum level of medication(s) to provide the greatest benefits.

Rosalind Goodrich: Agree. Medications can be very helpful, but it is worth the investment to engage additionally in many proactive, protective behaviors (exercise, journaling, social engagement, etc.).

QUESTION*: Is there an appropriate medication for an actively suicidal teen that won't increase suicidal thoughts?*

David Wood: The NIMH (nimhnih.gov) website recommends that adolescents given SSRIs to alleviate Major Depression should be closely monitored, especially during the first four weeks of treatment. SSRIs have benefitted many, but not enough is known about their interactions with youth, and the FDA has issued a serious caution. There are several SSRI medications, each with somewhat different properties. It would be wise to consult with a psychiatrist or medical doctor who specializes in or has experience with such cases to get the best and latest information regarding the benefits and risks.

Rosalind Goodrich: Agree. I suggest seeking the input of a psychiatrist, especially one that has experience with pediatric and adolescent populations. They can consult with your family doctor and other mental health professionals to create a good treatment plan for a teen.

QUESTION: *Can you talk about anxiety and panic attacks? What they are. What they look like. Treatment and helps.*

David Wood: Unfortunately it is beyond the scope of this format to adequately address these topics in and of themselves. However, as related to depression: with significant depression, elements of anxiety or even full-blown anxiety disorders may often be present. A professional should be consulted directly to formulate an appropriate course of treatment. Meanwhile, there are resources which may be accessed which provide basic quality information: nimh/nih, WebMD, NAMI, medlineplus, mayoclinic. Faith-based resources include: focusonthefamily, christianbook. These sites can be googled and their search programs used.

Rosalind Goodrich: Agree. Consider reading David Burns' "When Anxiety Attacks" book.

QUESTION*: I have been diagnosed with severe depression, generalized anxiety disorder, and PTSD. I have had very little luck with medication, especially generic antidepressants. I use exercise and prayer and counseling, but I feel hopeless that I will get better. Any advice?*

> **David Wood**: Hopelessness is a difficult feeling with which to contend. It clamors for one's attention, and clouds one's willingness to push on. As Christians we are admonished to focus on our Savior, His plan, and the joy of growing to know His infinite love for us. It can be helpful to confront these helpless-feeling creations of our thoughts with His revealed will for us. We may have to persevere in our efforts and rely on His strength, which may come from many directions and sometimes unexpectedly through others or new circumstances. The battle in the mind: confronting our experience vs. His Word and Spirit, can be fierce at times and long. Biochemically, there are many options to consider as well. Trying one or even a few "generic" medications may not provide the specific balance needed in a particular individual. But with each "failure" new information is added to the understanding. It could be time to review your history and current concerns with your doctor or a psychiatric specialist. Meanwhile, try not to isolate from believers and others who care. Sleep and nutrition can also affect mood. Share the concerns you have with your counselor and prescriber.
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> **Rosalind Goodrich**: One additional thought. It might be worth considering with your psychiatrist/physician and counselor—both the length of time, intensity, and trajectory of the PTSD, anxiety, and depression. Certainly, if this is a recent traumatic experience, it may take some time for symptoms to subside. Small steps forward are steps forward!

QUESTION: *How much does knowing the Word of God help in combatting depression?*

> **David Wood**: Soaking God's Word into our heart through study and meditation on His Word can be a great way to battle the temptation to believe negative lies about life, existence, and purpose. Yet God is not limited to affecting us solely by His Word, but also through His church, life circumstances, His Spirit, medicines, and even the unsaved. If the study of His Word alone seems not to provide the relief sought, perhaps expanding one's focus to other avenues of receiving His comfort and direction could prove fruitful in new ways. Being open to seeing and hearing Him through His creation more broadly can add to one's overall experience of Him, increasing one's sense of intimacy and awe of His majesty.
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> **Rosalind Goodrich**: Amen! I'd like to add that there are so many things about life that are challenging for us to understand and, in a sense, measure. We may subjectively feel like we aren't making progress (I'm imagining myself struggling, reading Scripture faithfully, yet not feeling any better!) but we might be making a kind of progress that we just aren't quite able to perceive.

QUESTION: *Are there any recent breakthroughs or help for cyclothymic Disorder? If left unmedicated, does it get worse (bipolar in family)?*

> **Rosalind Goodrich**: The challenge here is that every situation is so different. This often is a chronic situation, but like many other mental health challenges, context and life situations can frequently make symptoms worse—or lessen them; so it is hard to make certain prediction about any situation. For the bipolar disorders (of which cyclothymic is one), medication seems to be the

first-line approach, but coping skills and other mental health and behavioral support can also be worthwhile. It is important to consult with a provider who can more thoroughly explore the situation.

QUESTION: *Regarding spiritual resources: have you tried the following therapy:*

- *With coaching, purposely praise God for ten minutes three times daily.*
- *Continue for one week. Note how you are feeling compared to a week ago. See Psalm 102. State circumstance: praise. State feelings: praise.*
- *Repeat for one month*.

Rosalind Goodrich: I haven't implemented in that specific way, but spiritual practices—reading Scripture, prayer, and praise—are good practices to continue to grow in the Lord!