Heart Cry: A Biblical Model of Depression

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Depression is a problem of epidemic proportion and increasing frequency. Recent research shows depression to be produced by multiple, interacting and multiplicative factors. A biblical model of depression is presented which shows depression to be a motivational force that moves a person to action on one of two paths, the first leading to healing and restoration, the second to spiraling destruction. The spiritual components of depression are discussed and six different points of potential intervention are presented.

Depression, An Epidemic Problem

In 1990 almost 11 million adult Americans suffered a clinical depression, with an estimated cost to the U.S. economy of nearly 44 billion dollars (Greenberg, Stiglin, Finkelstein, & Berndt, 1993). This, however, only begins to assess the magnitude of the problem we currently face. These figures do not include childhood or adolescent depression. Nor do they include subclinical depression, whose symptoms have such a high prevalence (23.1% lifetime) that its social morbidity is equal to or greater than the conditions of major depression and dysthymia. Subclinical depression itself is considered a clinical and public health problem (Weissman & Klerman, 1992). Wells et al. (1989) found "The poor functioning uniquely associated with depressive symptoms, with or without depressive disorder, was comparable with or worse than that associated with eight major chronic medical conditions." Depression is, without a doubt, one of the major problems faced by mental health professionals and the church alike.

Even more disturbing than depression having already reached epidemic levels, is the fact that it is still increasing. Hagnell, Lanke, Rorsman, and Ojeso (1982) studied a normal population and found that men in the 20-39-year age group had a risk of moderate to severe impairment from depression that was ten times higher for the 1957-72 period compared with 1947-52. "In the mid 1960's it was estimated that one in ten Americans would suffer some time in life a depressive illness severe enough to require treatment; in the mid 1970's the life chances may have been as high as one in six" (Schwab, Bell, Warheit, & Schwab, 1979). More recently, Klerman and Weissman (1989) reported significant changes in rates of major depression found in large epidemiological and family studies: an increase in rates of cohorts born after World War II, a decrease in the age on onset, and an increase in the rate of depression for all ages during 1960 to 1975. The trends were evident in the United States, Sweden, Germany, Canada and New Zealand, but not in Korea, Puerto Rico or in Mexican Americans living in the United States. Similar increases were found in approximately 39,000 subjects in samples from nine epidemiological surveys and 4,000 relatives from three family studies in the 1980s in North America, Puerto Rico, Western Europe, the Middle East, Asia and the Pacific Rim (Cross-National Collaborative Group, 1992). They reported increasing rates

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of major depression over time for all sites with the magnitude of the increases varying considerably with the site.

Further, once a person experiences an episode of major depression he or she has an increased probability of experiencing a second episode. In a study of four treatment groups (cognitive therapy, interpersonal therapy, antidepressant drug therapy and placebo drug therapy), Shea, Elkin, Stanley, and Imber (1992) found that the probability of relapse was equal for all four groups, averaging 20% in 12 months and 38% in 18 months. Maj, Veltri, Pirozzi, Lobrace, and Magliano (1992) found in a prospective study that the probability of avoiding relapse after an episode of major depression was 76% at the end of six months, 63% at the end of one year and only 25% at the end of five years. They also found that there was a pattern of increasing severity from the original episode to the succeeding first, second and third relapse episodes. Increasing severity can also be seen in increasing social morbidity in bereaved spouses (Zisook & Schuchter, 1993). They found higher percentages of morbidity in some areas of social function, including dissatisfaction with work performance, increased mistakes at work, more health problems, and worsened social relationships at 19 months compared to two months post-bereavement.

Post (1992) postulated that having an episode of depression leaves behind neurobiological residues which increase a person’s vulnerability to a subsequent episode. Because of both stressor and episode sensitization, it takes less of a stressor to evoke greater behavioral consequences. He further suggested that different psychological and/or biological interventions may be required depending upon the longitudinal stage of the person’s depression.

If we are to stem the apparent rising tide, we must act with understanding, using interventions based on the total of what we know, rather than rely on any single tack, whether it be cognitive restructuring, reinforcement, prayer, forgiveness or Prozac. Just as in treating fever, we have to approach the treatment of depression with the fullest knowledge of its etiology and courses possible.

Depression’s Multiple Interactive Components

Most nosologies, including DSM-IV (American Psychiatric Association, 1994) provide classifications of depression based upon symptom presence, severity and duration (see Hirschfield, 1991 for a history of the classification of depression). Yet because they typically do not address the important issues of etiology or subclinical depression, and totally ignore the spiritual components of depression, they are of limited value in either the understanding the nature or treatment of depression. Studies have consistently demonstrated multiple biological (see Gershon, Berrettini, & Goldin, 1989 and Schildkraut, Green, & Mooney, 1989 for reviews of biochemical and genetic components respectively), social (Billings & Moos, 1985; Howland, 1993, Keitner, Ryan, Miller, & Norman 1992; Van Wicklin, 1990) and psychological (see Sacco & Beck, 1985; Hoberman & Lewinsohn, 1985; and Peterson & Seligman, 1985 for respective reviews of cognitive, behavioral and learned helplessness approaches to components of depression). Additionally, depression may be symptomatic of a physiological illness, such as infectious disease and endocrine problems. (see Cameron, 1987, and Hall, 1980, for reviews of the medical presentations of depression). Spiritual issues in depression have for the most part been ignored in the literature (Larson et al., 1992), but there is a growing body of data which point to a strongly positive role of religious commitment variables in alleviating depression.
Genia and Shaw (1991) reported intrinsic religious commitment to be associated with lower levels of depression. Spiritual well-being was found to be inversely associated with depression and negative mood states, as measured by the Beck Depression Inventory and Profile of Mood States (Fehring, Brennan, & Keller, 1987). Koenig et al. (1992) concluded that religious coping is a common behavior that is positively related to lower levels of depression in hospitalized elderly men. In a review of the empirical literature, Gartner, Larson and Allen (1991) reported that at least 70% of the time religious commitment was associated with improved coping and protection from psychological problems, including depression and suicide.

Citing disciplinary fragmentation, nosological and semantic controversies as significant obstacles to understanding and treating depression, Akiskal and McKinney (1975) reviewed ten conceptual models of depression and presented a framework which integrated them. They postulated complex interactions of multiple behavioral, biological and social systems in the etiology of depression and emphasized that a simple one-to-one relationship between a specific chemical event in the brain and a behavioral syndrome is an untenable approach. Their work also suggested that the symptoms of depression could become etiologic and thus maintain and exacerbate the problem. Such a formulation is supported by a study of 680 female-female twin pairs (Kendler, Kessler, Neal, Heath, & Eaves, 1993) which found at least four major and interacting risk factor domains in the etiology of major depression: traumatic experiences, genetic factors, temperament and interpersonal relations. They also concluded that the variables are not merely additive, but are likely multiplicative. The American Psychiatric Association Task Force on Treatments of Psychiatric Disorders (1989) provided a good review of an integrative behavioral model for the etiology and maintenance of depression.

Some authors have written about depression being misdiagnosed when there actually was a biological disease present (Gold, 1992). This is not likely the true problem. It is more probable that depression in such cases had been accurately diagnosed, at least according to accepted DSM-IV or ICD-9 (1978) standards, but what was mistaken were the etiologic assumptions which obviously are crucial. Intervention needs to be designed according to a differential diagnosis based upon the etiology of the depression as well as its symptom characteristics.

It is clear that depression is a syndrome with multiple, interactive factors which are drawn from biological, psychological and sociological domains. What is equally clear, however, is that our advancement in knowledge of depression and its treatment remains limited until the role of spiritual factors is equally well delineated. It is to this factor that we now turn our attention.

**Heart Cry: A Biblical Model of Depression**

The Bible provides us a framework for understanding depression which not only is congruent with our existing scientific knowledge base, but also encompasses our concerns about the etiology and course of depression. First, depression is seen as a state of mind, body and spirit that emanates from the core of our being, or heart (II Cor. 2:4, Is. 65:14, Jer. 8:18, Jn 6:6). It is a state of heart, or heart cry, designed by God to motivate or move us to action. Paul writes “for Godly grief and the pain God is permitted to direct, produce a repentance that leads and contributes to salvation and never brings regret; but worldly grief (the hopeless sorrow that is characteristic of the pagan world) is deadly, breeding and ending in death.
(II Cor. 7:10, Amplified Bible [AB], 1965). This grief is active; it produces or it breeds. Either way, it is a force which moves us to action. Before we look further at how it moves us, let's examine what produces this response in our heart.

There are two categories of events which can produce this motivating "heart cry." One comes from a sensitivity to situations outside of ourselves. Out of this heart-heaviness we are moved to minister to the needs of others. We can all identify with this, the times we've experienced heart-heaviness over the pain or circumstances of someone else, out of which we are moved, sometimes well beyond the expected, to help. Scripture has many examples of this—Jeremiah wrote of his heart being "sick and faint within him" (Jer. 8:18, AB), out of which he interceded for Judah and was willing to be the Lord's messenger, bearing warning and opportunity for repentance and deliverance to his brethren. Nehemiah's "heart cry" moved him to leave his comfortable position to rebuild the walls of Jerusalem (Neh. 1:8-11). Paul was moved to confront the church at Corinth "out of great sorrow and deep distress of heart and with many tears" (II Cor. 2:4). A confrontation that eventually produced repentance, change, a restoration of joy, comfort and encouragement (II Cor. 2:7-11, 7:12-16).

The second category has to do with those things within ourselves that need correction; a response to, or consequence of, violating the way we have been made. Our heart is designed to be exquisitely responsive to the presence of God. His absence, or even the threat of it, produces a response of intense grief and sorrow. Isaiah proclaimed this clearly in the two messages he brought, one for those who received and followed God, the other for those who forsook God. For the first "My servants shall sing for joy of heart" (Is. 65:14); but for the latter, who chose to abandon God, "you shall cry out for pain and sorrow of heart, and shall wail and howl for anguish, vexation and breaking of spirit" (Is. 65:14, AB). Such depression was not punishment, but rather a natural consequence of the heart being violated. Peter experienced this painful "heart cry" after denying Jesus (Mk. 14:72). The disciples experienced similar pain when they learned that one of them would betray the Christ and were fearful that they might be the one facing separation from his presence (Matt. 26:21-22, AB) and again when Jesus directly told them they would soon be separated from him (Jn. 16:20-24, AB). Without question the most powerful example of this heart sorrow is that experienced by Jesus himself when he said "My soul is very sad and deeply grieved, so that I am almost dying of sorrow" (Matt. 26:38, AB). Jesus, who knew no sin, who was completely one with the Father, was to become sin on the cross and experience complete separation from God. So we see depression as a "heart cry" designed to move us back into full relationship with our Creator or to minister to the needs of others.

The Scripture provides us with additional potential causes of this "heart cry," many of which involve things which obscure or impair our relationship with God. These include, but are not limited to:

- overwhelming experiences and "helplessness" from captivity (Ex. 6:9 and Lam. 5:17)
- anxiety and fear (Deut. 31:8)
- disobedience (Deut. 28:65)
- extreme obstacles and danger (David's response vs. Saul's army's response, 1 Sam. 17:11; the mariners' response vs. Paul's response, Acts 27:20-22
- exhaustion (Moses asks God to take his life, Ex. 18:13-18 & Num. 11:14-15; Elijah wants to die, 1 KI. 17-19)
- lack of vision (Prov. 29:18)
- loss of important heart-relationships (Jacob, Gen. 37:34-35; David, II Sam. 12:15-24; Job, Job 17:1 & 7)
- guilt (David, Ps. 32:1-5)
- anger and bitterness (Jonah, Jonah 4:9; Cain, Gen. 4:5-6)
- pride and self-indulgence (Ahab, I Ki. 21).

So we see that a heart response of grief or sadness can be caused by a variety of events and experiences, both within and/or external to ourselves. This scriptural model is consistent with the multiple etiology of depression cited in the literature, with depression being elicited by a variety of psychological, social and spiritual events. With this established we are ready to look at the course of depression and the actions produced by this “heart cry.”

Paul wrote to the Corinthians about both grief directed by God and worldly grief (II Cor. 2:10). The word translated grief, lupe, means sadness, grief, heaviness and/or sorrow and is used for both godly and worldly grief. Lupe thus identifies one emotion with two possible courses. The first is life bearing; the second a breeding, death-producing spiral marked by hopelessness and destruction. Put another way, depression is a negative state which moves us toward life-bearing action, or if unheeded, toward death.

In response to the heart-sorrow, there is a corresponding action which leads to healing and strengthening, rest and restoration for exhaustion, repentance and forgiveness for guilt, healing and fullness in relationship with God. The literature cited earlier strongly supports this positive or life-producing pathway. Different psychological and social events appear to reduce depression, and religious commitment is consistently demonstrated to be associated with less depression, as a successful coping strategy for dealing with events which produce depression, and as prophylactic for the development of depression. When the etiology of the depression is addressed, the negative motivating state is transient. There is also a second pathway which has a course leading to a very different outcome.

The alternative pathway is described by the Holy Spirit, through Paul (II Cor. 7:10), as being breeding, destructive and ending in death. The emotion in the heart is the same, but it does not find resolution. Instead, it spirals downward. Feelings, thoughts and behaviors interactively spiral the person deeper into depression. Feelings of guilt, rather than finding release in repentance, grow and foster feelings of abandonment or estrangement from God and a growing conviction that this is what is deserved. Anger smolders in resentment and hatred. Unrestrained, overpowering dysorphic feelings seize control. Progressively, the feelings become the basis for more and more central decisions and thus alter as well as limit the field of choices. These feelings are fueled by a steady flow of thought which also is steadily increasing in its depressive content. The person’s entire cognitive perceptual framework of both self and the world becomes part of the depressive spiral, intensifying the feelings of hopelessness and powerlessness.

Together the thoughts and feelings interact with a third component, behavior. Behaviors can reinforce and provide authenticating feedback that the depression-dominated cognitions and feelings are valid. Such behaviors cover the entire spectrum of withdrawal and disengagement from activities and life involvements which run counter to the depressive spiral. More and more behaviors that are stimulating and intrinsically rewarding are abandoned. Behaviors that limit or totally prevent meaningful, healthy emotional relationships with other people, are increasingly adopted.
The Scriptures (II Cor. 7:10) describe this process as breeding and ending in death, and this is precisely what happens. This spiral of thoughts, behavior and feelings produces more events capable of eliciting the heart response, which in turn increases and deepens the spiral. What we know of the cognitive and behavioral components of depression from the cited literature fits well with this formulation. This is particularly true of the theories which postulate multiple, interacting behavioral and biological components that are multiplicative and that directly produce more events which in turn are etiologic of depression. Thus this biblical model provides us with an understanding of the various etiologies of depression, the normal and destructive courses of depression, and with an additional dimension which we cannot afford to ignore as Christian professionals.

King David is known for calling out to God in the midst of despair and depression (Ps. 38:8, 33:3, 13:2). When everything seemed to be caving in he would consistently look to the Lord, expecting him to deliver him out of his troubles (Ps. 38:15, 33:7, 13:5). From the lion, the bear and the giant, David knew God as deliverer. The prophet Isaiah proclaims Christ as deliverer (Is. 61), saying that he came to bind up and heal the broken hearted, to deliver captives from their prisons. Deliverance is commonly thought of as a dramatic, sudden supernatural event which removes the feelings and takes away or solves the problems. While this happens, what is more typical is deliverance that is a progressive process.

Each time people find themselves in a spiral of depression, deliverance is available. This is a supernatural event. The original causes of the depression, or “heart cry,” still have to be dealt with, but deliverance out of the destructive spiral, placing the problems directly back on God's restorative path, is available. In the process of healing it may be necessary to be delivered out of a negative and/or destructive process with some frequency, until the causes have been fully addressed and/or new methods of dealing with them have been learned.

Implications for Treatment

If depression is in fact a syndrome of multiple, interacting, multiplicative etiologies, our interventions need to reflect it. The biblically based model presented here is predictive of multiple points of intervention, all of which have potential for relieving the experience of depression (see Figure 1).

People seen by a mental health professional for depression are typically caught up in a significant destructive spiral, making interventions to counter the spiral a high priority. The first step toward this is an assessment of possible medical etiology. This is not an attempt to determine whether or not there is neurochemical involvement; by definition there has to be, but the neurochemistry is not necessarily etiological. It is, rather, an essential evaluation for possible medical illnesses which are known to be directly causative of mild to severe depression. If this has been accomplished, a detailed behavioral, spiritual and social assessment should be completed. If not, a concurrent referral for medical evaluation by the patient’s primary care physician should be made. This emphasis on a medical evaluation does not give physiological etiology primacy in depression; it is rather a recognition that there are cases of depression produced by a tumor, thyroid, hormonal or other medical problem which requires the attention of a qualified physician. Second, the referral is for concurrent evaluation; for the presence of a medical problem does not preclude other, coexisting, etiologies. The treatment plan should then reflect spiritual, physiological, social and
Figure 1
Depression Courses and Interventions

CAUSES
Separation from God, Anger, Fear, Loss, Guilt, Lack of Purpose, etc.

DEPRESSION
(HEART CRY)

GOD’S PATH

NEEDED ACTION

DELIVERANCE

(1)

RESOLUTION

INCREASED SENSITIVITY, WISDOM, RESILIENCE, HOPE

LIFE

WORLD’S PATH

FEELINGS
Hopelessness Despair, etc.

THOUGHTS
Pessimism, Self-Rejection, etc.

BEHAVIORS
Self-Defeating, Withdrawal, etc.

MEDICATION

DEATH

(2) (3) (4) (5)
psychological interventions based upon the findings of the multifactorial assessment.

As we can see in Figure 1, there are at least six different points of potential intervention available to us. Point 1 includes interventions to help the person seek deliverance away from the destructive spiral and back to God’s restorative path. This is obviously dependent upon the person’s relationship with God and a willingness to call upon God directly. Some people have been so damaged by other Christians, or are too angry and/or fearful of God to pursue deliverance directly and/or on their own. In fact, when we as therapists prayerfully intercede for our patients we are intervening at this point ourselves, asking God to directly help, relieve, deliver, etc. The initial appraisal of the patient’s spiritual well-being should provide sufficient information to guide the therapist in the specific way she or he approaches this intervention.

When the intensity of spiraling symptoms makes it difficult for the person to function or threatens well-being, the focus of treatment needs to be intervention directly into the size and/or intensity of the spiral itself, along with pharmacologic treatment and other somatic interventions, such as electroconvulsive therapy. These interventions are a high priority because of the relative speed of symptom improvement, particularly with the new generation of selective serotonin reuptake inhibitors which increase the energy available for dealing with the other factors causing the depression.

Next are interventions (points 2-4) dealing with the feeling, thought and behavioral components of the spiral. When overwhelmed by a spiral of depressive symptoms, the feeling state increasingly dictates both the numbers of options perceived and the actual choices made. The dominant feeling state selectively eliminates choices that appear too difficult to carry out. As the depressive spiral grows, even simple behavioral options, such as self-care or getting out of bed, are filtered out. The therapist can use a psychoeducational strategy to help clients understand what is happening to them and how their feelings are being used to the exclusion of their intellectual assessment and spiritual discernment capacities which are still intact and available to them. By beginning at the simplest level of decision making, areas well within the patient’s control and ability, the therapist helps the person re-experience coping strengths, much like the healing and restoring of a badly weakened muscle. Gradually, and increasingly, interventions in the area of feeling-dominance begin to increase the spectrum of perceived options and engender a renewed sense of hope and personal empowerment which can then be drawn upon to deal with more complex and/or emotionally painful or threatening issues. Interventions at this level would also include helping develop spiritual activities or behaviors that would increase the ability to relate to God and begin to draw more on spiritual discernment in making choices; in essence helping the person learn practically that God has provided a spirit of power, love and a sound mind (II Tim. 1:7).

Dealing with the second component of the spiral, thoughts, involves interventions quite familiar to the mental health professional and needs little attention here. Psychologically, these are represented by the cognitive approaches to treating depression (see Beck, Rush, Shaw, & Emery, 1979; Lipsker & Oordt, 1990). Spiritually, this is taken a step further and includes leading “every thought captive into the obedience of Christ, the Messiah, the anointed One.” (II Cor. 10:5, AB). The goal of the therapist is to help a depressed person develop a healthy cognitive system which is reflective of biblical truth about themself and their world. These interventions vary in degree from the mental disciplines we all need to a complex effort to assist the person in restructuring much of their cognitive field.
The last entry point into the components of the depressive spiral deals with behavior. The simplest level of behavioral intervention is that dealing with helping patients increase basic sustaining behaviors, including eating, sleep habits and mild exercise. Engagement behaviors are a second group of behaviors which require attention and involve those behaviors that access the person’s normal life activities and relationships and counter the withdrawing, vegetative processes. The third class of behaviors requiring intervention are clinical behaviors, which include a wide range of dysfunctional patterns as well as behavioral and relational systems which exacerbate and maintain the depressive spiral. For behavioral strategies in approaching the more complex behavioral involvements, the reader is referred to Lewinsohn, Steinmetz, Antonuccio, and Teri (1984-85) and Seligman (1990). Spiritual interventions would include the development of both personal spiritual behavior such as prayer, personal worship, reading Scripture and external religious involvement such as participating in corporate worship and body ministry in its various forms.

To this point we have dealt with interventions which help the person deal with depression on God’s restorative path or diminish the destructive spiral itself. Interventions at this level should diminish the dysphoric feelings, inhibit further deterioration, and increase the amount of emotional and spiritual energy available. It should also be clear that these interventions are concurrent, not consecutive efforts, each interacting and multiplying the others. Because of their interactive nature, as positive choices are made and healthy actions taken, a positive cycle can be initiated that stimulates and feeds further positive decisions and action. It is the therapist’s responsibility to detect even small changes and give feedback. This is particularly important until the person begins to develop an intrinsic feedback system that allows perception of positive changes and successes.

The sixth and last point of entry in dealing with depressive problems is the identification and remediation of any of the possible causes which produce the heart cry. While this is not a consecutive intervention, the person’s ability to successfully identify these causes and implement appropriate actions may be limited by the depth and intensity of the depressive spiral. As the spiral diminishes, more exclusive attention can be given to the various etiologies which seldom, at least in a counselor’s office, occur in isolation. The specific intervention is then dictated by the etiologies present (guilt, exhaustion, etc.).

Conclusions

Depression is a serious, growing problem which mandates our attention. Research has shown it to be a syndrome with multiple interactive causative factors that are multiplicative. The Bible provides us with a framework that takes into account the most current scientific findings from which we can understand depression, its multiple causes, its varying degrees of intensity and course, as well as its critical spiritual dimensions. From this framework a wide range of spiritual, psychological, social and physiological interventions are possible, depending on the etiological factors and the course of the depression.

REFERENCES


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