The Normal and Pathological Genesis of Depression: The “Heart Cry” Biblical Model of Depression Revisited

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The Heart Cry Model (HCM) of Depression posits that depression is a normal, negative motivational state with a spiritual base, moving one toward corrective action. This depressive response can be elicited by multiple causative events capable of separating one from God or creating the felt-perception of separation. Once elicited, the depressive response or “Heart Cry” takes one of two tracks, either the God-designed corrective path, or a path of spiraling destruction. A review of depression research relevant to the basic structure of the model, and its spiritual foundation, is presented. The implications of the HCM for both corrective and preventive intervention are discussed.

The need to understand depression, and thereby design effective preventive and corrective interventions, has increased since the “Heart Cry”, biblical model of depression was first presented (Armentrout, 1995; Armentrout, 2000). Major depression is currently the leading cause of disability (both mental and physical) in the US (NIMH, 2001), and worldwide among persons five years old and older (Murray and Lopez, 1996); the costs are staggering, with $12.4 billion a year going to direct costs (medical, pharmaceautical, psychiatric) and an estimated total annual cost of $43.7 to $52.9 billion (Pincus & Pettit, 2001). Yet, sadly, the highest cost is human, with 44% of all disability adjusted life years (years of healthy life regardless of whether they were due to premature death or disability) caused by major depression, and an additional 14% accounted for by suicide (Murray & Lopez, 1996).

The confluence of two phenomena projects an even bleaker reality for the future, if nothing is done to alter the current course of depression. First, depression is seldom discrete, or self-limiting. Most sufferers (73.9% of major depression and 69.2% of minor depression) have recurrent episodes (Kessler & Walters, 1998), 40% last for over a year (Pincus & Pettit, 2001), and 15-20% will never remit (Cardot & Rouillon, 1995). The second compounding factor is the rate of occurrence itself. Increasing rates of depression continue to be reported in both adult (Angst, 1995; Kessler & Walters, 1998; Sandanger, Nygard, Ingebrigtsen, Sorenson & Dalgar, 1999) and adolescent (Prosser & McArdle, 1996; Kessler & Walters, 1998) populations, and the age of onset is becoming lower (Bland, 1997; Sandanger, et al., 1999).

One interesting study of problems seen in a college counseling center (Benton, Robertson, Tseng, Newton & Benton, 2003) found that from 1988 to 2001 the number of students seen with depression doubled and the number of suicidal students tripled. At the same time legal problems and chronic mental illness showed no significant change and substance abuse and eating disorders remained stable. Further, most of these findings are based upon studies of diagnosed major depression, excluding other manifestations of depression. Sadeck and Bona (2000) discuss depression as a spectrum, with Subsyndromal Depression or SSD (a depressive state with two or more symptoms of the same quality as Major Depressive Disorder excluding depressed mood and anhedonia) being the mildest form, followed in increasing intensity/severity by the DSM IV categories of Minor Depressive Disorder (MinD), Dysthymia and Major Depressive Disorder (American Psychiatric Association, 1994). This is important because SSD carries its own significant morbidity of impairment, risk of suicide and future major depression, and its prevalence combined with MinD exceeds the prevalence of all DSM III affective disorders combined (Judd, et al., 1994).

It is the impetus of these data that mandates a re-examination of our models and suppositions...
regarding depression and its treatment, and in particular that we turn to God’s word to guide the way. An interesting finding in regard to the spiritual dimension (Cooper, et al., 2000) indicates that many of those we wish to serve already desire the recognition and inclusion of spiritual factors in their treatment. The authors reported that in a survey of primary care patients, intrinsic spirituality ranked sixth out of 126 items of importance in the care of depression.

One model, the HCM or “Heart Cry” model (Armentrout, 1995; Armentrout, 2000), is based upon the premise that depression is a spiritual phenomenon as well as biological and psychological. According to the HCM, depression is a God-designed, normal, negative motivational state that moves one to corrective action, a response elicited by the felt-perception of being separated from God. The over 70 Hebrew and Greek words used in the Bible to refer to depression, sadness, heaviness, etc. point to multiple phenomena (ranging from the obvious like anger and guilt to others such as disobedience, exhaustion and lack of purpose) that have causative capacity (Armentrout, 2000). The course of this response is described to us by the apostle Paul:

“For Godly grief and the pain God is permitted to direct, produce a repentance that leads to and contributes to salvation and deliverance from evil, and it never brings regret; but worldly grief, the hopeless sorrow that is characteristic of the pagan world, is deadly—breeding and ending in death.” (II Corinthians 7: 10, AMP)

The depressive response (“Heart Cry”) then can take one of two tracks (See Figure 1), either the God-designed corrective path which leads to life-restoring change and resolution of the depressive state, or alternatively, a spiraling destructive path with intensifying dysphoric feelings, attendant thoughts and behaviors. What follows is a presentation of the major components of the HCM and their relationship to empirical findings in the extant literature.

The Spiritual Foundations of Depression

Central to the HCM is the premise that depression is etiologically spiritual. While references to spirituality related to the HCM are intended to reflect what Benner (1998) referred to as Christian Spirituality ("the deep relationship with God that occurs when the human spirit is grounded in the Holy Spirit"), many conceptions of spirituality and religiosity are found in the literature. The language and terms used in this article attempt to reflect the various authors’ views of spirituality and religion.

Hassed (2000) suggested that the widespread decline in mental health in Western society may in part be due to a decline in spiritual fulfillment and lack of meaning, and Morris (1996) reported that many symptoms of depression parallel indications of spiritual distress. More specifically the HCM, based upon many scriptural examples (Armentrout, 2000) posits that perceived spiritual loss (produced by a number of physical and/or cognitive events that diminish one’s awareness of God’s presence, such as fear, exhaustion, pain of loss, etc.) or things that separate one from God (manifestations of sin), will cause depression. Further, the “Heart Cry” or depressive response is also produced when the plight (loss, suffering, sin, etc.) of others touches the Christ-softened heart. In general, studies have shown that religious involvement and spirituality are associated with less depression and suicide (Fehring, Brennan & Keller, 1987; Somlai et al., 1996; Chang, Noonan & Tennstedt, 1998; Mueller, Plevak & Rummans, 2001; Baetz, Larson, Marcoux, Bowen & Griffin, 2002; Patel, Shah, Peterson & Kimmel, 2002; VanNess & Larson, 2002), and have lower rates of depression (Hallstrom & Persson, 1984). The intrinsically religious are also 55% less likely to be diagnosed with major depression (Spendlove, West & Stanish, 1984). At the same time, some studies have found spirituality related to higher levels of depression (Richards & Folkman, 1997), the buffering effects of religion, while generally positive, tend to be only modest in strength (VanNess & Larson, 2002) and the findings are mixed on whether religious beliefs are predictors of depression (Koenig, McCullough & Larson, 2001).

These findings are consistent with the HCM predictions, as are those of Balk (1991), who found that religious youth experienced far more depressive symptoms than did non-religious youth at the death of their sibling. But by the time of the interview (an average of 24 months post-loss), the religious youth had only mild symptoms while non-religious youth were still significantly depressed. Thus, while the Christ-softened heart may make one more susceptible to depressed feelings (“heart cry”), the course of recovery should be faster (Koenig, George &
Figure 1. “Heart Cry” Model of Depression and Points of Intervention.
Peterson, 1998) and less likely to multiply into destructive depression (Spendlove et al., 1984). In their study of medically ill elderly, Koenig et al. (1998) demonstrated this dramatically in their finding that a ten point increase on the religious motivation scale was associated with a seventy percent increase in the speed of depression remission, and that among subjects whose disability worsened or remained unchanged during the one year follow-up, the speed of remission increased by more than 100% for every 10-point increase on the intrinsic religiosity measure.

The Normal, Motivational Function of Depression

A second central tenet of the HCM is that depression is a normal, motivational state (“Heart Cry”) that moves us to assessment and corrective action for ourselves and/or others. There is a growing body of empirical and theoretical literature that supports this contention. Depression has been asserted to be a normal, adaptive and homeostatic process that facilitates adaptation (Gut, 1989; Patten, 1999). It has been described as a biochemical (Post & Weiss, 1992), biological (Patten, 1999) and evolutionary (Price, Sloman, Gardner, Gilbert & Rohde, 1994) process, and also as a mechanism of intelligent systems (Webster, 1995), a social response in hierarchical encounters (Sloman, Price, Gilbert & Gardner, 1994) and a stress response (Hewson, 1997). However, all have in common the normality of depression, that it is an adaptive response and that it moves us. The latter may be an inner re-examination (Schildkraut, Hirshfeld & Murphy, 1994), or the development of new coping strategies in a dangerous, stressful or threatening environment. The motivational nature of depression is seen in the five hypothesized phases of what Gut (1989) called the normal depressive response. These include: (1) a striving to reach some significant goal by applying personal resource, (2) perplexity (defined by Gut as awareness that the expected progress toward this goal has not been realized), (3) the taking over by an intense, largely unconscious preoccupation in which the obstruction is experienced as disquieting and feelings of disequilibrium and urgency arise, (4) efforts are mobilized within the person to remedy the situation by devising new solutions, and finally (5) there is more intense information processing which includes comparison, integration and revision of new and past perceptions and of recently reached conclusions with long-established beliefs.

Depression’s Multiple Causation/Elicitation

If depression is in fact an adaptive, motivational response, then it is logical that many internal and external events would be capable and sufficient to elicit it. According to the HCM, anything capable of separating us from God, or creating the felt-perception of separation, is capable of triggering this motivational response. In other words, the HCM (Armentrout, 2000) predicts that many events (fatigue, disobedience, guilt, loss, etc.) can produce the God-designed “Heart Cry” which moves us to corrective action and/or intervention. This prediction is very consistent with the literature implicating multiple etiologic factors (Patten, 1999; Sullivan, Neale & Kendler, 2000; Kendler, Gardner & Prescott, 2002), and we have already reviewed the evidence that links depression to spirituality, and that spiritual distress (Morris, 1996) may be etiological. Depression has been shown to be related to environmental stress (Broadhead & Abas, 1998; Patten, 1999; DeMarco, 2000; Kendler, Gardner & Prescott, 2002), guilt (Ney, 1979; O’Connor, Berry, Weiss, & Gilbert, 2002; Ghatavi et al., 2002; Resick, Nishith, Weaver, Astin & Fever, 2002), anger (Farmer, 2002; Koh, Kim & Park, 2002; Lutenbacher, 2002) and fatigue (Addington, Gallo, Ford & Eaton, 2001). Two closely related factors, connection to others and loss, have also been shown to be related to depression. For the former, low levels of parental bonding in childhood (DeMarco, 2000), disruption of normal attachment patterns (Cicchetti & Toth, 1998), inadequate social networks (Olsson, 1998) as well as never being married (DeMarco, 2000) were associated with depression. Interestingly, even connection through Internet use (Shaw & Grant, 2002) was found to decrease depression and loneliness. Loss of connection through bereavement (Broadhead & Abas, 1998), divorce and/or separation (Weissman et al., 1996; DeMarco, 2000; Patten, 2001) and through family stressors and child problems (Strawbridge, Shema, Cohen, Roberts & Kaplan, 1998) have all been associated with higher levels of depression.

The lack of a sense of self worth (Sakamoto, Tumoda & Kijima, 2002; Vinas, Canals, Gras, Ros, & Domenech-Llaberia, 2002) and loss of worth through humiliation (Broadhead & Abas, 1998) have been shown to be related to depression. Further, life meaning (Klass, 1998; Nelson,
Rosenfeld, Breibart & Galietta, 2002) and purposefulness (Schildkraut et al., 1994; Coleman & Holzemer, 1999) were associated with depression and with recovery from depression (Gorruble, Duret, Pelissolo, Falissard, & Guelfi, 2002). Finally, as with King Ahab (Armentrout, 2000) self-preoccupation has been correlated with the severity and duration of depressive episodes (Sakamoto et al., 2002), while narcissism (Stucke & Sporer, 2002) and self-focus (Mor & Winquist, 2002) have been predictive of negative affect, and self-transcendence (Klass, 1998; Ellermann & Reed, 2001) inversely correlated with depression. It can be seen from the association of the single phenomenon of depression with such diverse findings, that multiple events and experiences have the capacity and are sufficient to elicit the depressive response.

The Course of Depression: Continuous Phenomenon with Two Pathways

According to the HCM, depression is a continuous, motivational response designed to move the person toward corrective action, but which, if left unattended, can follow a second pathway. Once again, we find the recent literature supportive of this thesis. The various “types” of depression have been shown to be strongly comorbid (Lewinsohn, Rohde, Seeley & Hops, 1991), share many, but not all symptoms (Sadek & Bona, 2000), and may be differing aspects of the same disorder (First, Donovan & Frances, 1996). In fact, in a study of female twins, Kendler and Gardner (1998) concluded “DSM IV may be a diagnostic convention imposed on a continuum of depressive symptoms of varying degrees and duration” (p 172). This conclusion is consistent with Sadek and Bona (2000), who view depressive symptoms as mobile and changing over time rather than static, and with Flett, Vrendenburg and Krames’ (1997) view that the evidence is consistent with qualitative differences on a continuum in depression rather than kinds, or qualitative differences. The most compelling evidence comes from Ruscio and Ruscio’s (2000) taxometric analysis which assessed whether major depression represented a structurally discrete entity or, alternatively, the endpoint along a continuum of depressive symptomatology. In other words, they investigated whether or not the underlying nature or structure of depression is continuous (dimensional) or categorical (taxonic). They noted that the formulations of the Diagnostic and Statistical Manuals of Mental Disorders (American Psychiatric Association, 1994), and subsequent practice, consider major depression as a “qualitatively discrete” syndrome whereas research suggests that major depression may differ only quantitatively from normal emotional experience. The reader is encouraged to see the details of these two important studies (Ruscio & Ruscio, 2000), the results of which both failed to find a depression taxon, and were supportive of the dimensionality of depression.

Having established support for the notion that depression is a continuous response, we now look at another central premise of the HCM, that this response can take one of two different tracks. The first line of support comes from the spirituality and depression literature cited earlier, particularly the Balk (1991) study, which showed that two groups with similar pathogenesis had two distinctly different outcomes, and the work of Koenig et al., (1998) which demonstrated that different outcomes were associated with religious and non-religious pathways. Other studies have found that psychosocial stressors play a more significant role in initial episodes of depression and less so in recurrent ones (Post, 1992; DeMarco, 2000; Kendler, Thorton & Gardner, 2000). Gut (1989) noted that depression can be diverted from its’ normal adaptive function to serving a defensive function, such as maintaining denial instead of facilitating intensified information processing. Lewinsohn, Allen, Seeley, and Gotlib (1999) reported that there are distinct processes involved in the onset of first and recurrent episodes of major depression. Patten (1999) also pointed to two pathways, but attributes the second, and destructive path to symptom severity; an attribution that is not supported by the findings of Balk (1991).3 And finally, in considering two outcome paths, Webster (1995) speculated that much could be understood about the destructive pathway by studying the normal. While there appears to be agreement in the various findings that there are two pathways for depression, the nature of the second path remains a point of discussion. As we look further, we will see that the second pathway is qualitatively different from the first, not merely quantitatively, and needs to be understood in its own right.

Depression’s Destructive, Self-Maintaining & Multiplying Spiral

Indirect evidence of a destructive path comes from the high level of recurrence (Cardot &
Rouillon, 1995; Kessler & Walters, 1998; Pincus & Pettit, 2001) and chronicity already discussed, implying that the normal, corrective path of depression has been impaired or distorted. Silverman, Silverman and Eardley (1984) suggested that those who have been depressed have an increased vulnerability to depression. Increased vulnerability would help explain the high recurrence of depression. It is also consistent with the postulation of a central disturbance that develops with depression reflecting phenotypic variations of neuroendocrine processes (Griffiths, Ravindran, Merali & Anisman, 2000), with this underlying neurochemical disturbance serving to increase the probability of relapse. Relapse, however, is not merely a re-occurrence of a former problem. Leverich, Post and Rosoff (1990) reported four relapse characteristics during ongoing pharmacological treatment that include patient noncompliance, breakthrough episodes, illness exacerbation with psychosocial stress and progressive emergence of depression. This would suggest that the process under treatment is not static, but rather, dynamic and symptomatically intensifying. In their comparison of anxious, depressed and normal subjects, Ingram, Kendall, Smith, Donnell, and Ronan (1987) found the information processing of depressives to be qualitatively different from the others, and report that the outcome of this processing is “a maintenance and possible exacerbation of their negative affective states” (p. 179). Nolen-Hoeksema, Girgus and Seligman (1992) also pointed to the qualitative differences in this pathway in their five-year study that showed negative events, and not explanatory style, predicted depressive symptoms early in childhood, but later in childhood, a pessimistic explanatory style emerged as a significant predictor of symptoms. This style not only contributed to the experience of depression, but also persisted beyond the episodes’ resolution, increasing risk of future episodes. Depression on this pathway becomes self-maintaining and perpetuating. Patten (1999) found that depression did not resolve despite a return to pre-episode levels of environmental stress. What he further describes as a “vicious cycle of maladaptation” is initiated, with an impairment in ability to adapt to environmental stress, and also with a subsequent accumulation of stressful circumstances and experiences. We have come full circle; we have described a pathway of depression that is not only destructive, but it also produces events that are in themselves depression generative.

It is a logical extension then to hypothesize that when depression moves a person along the God-designed path, resolution occurs, and the experience is both corrective and self-limiting. Support for this is reflected in the increased speed of remission reported by Koenig et al. (1998), reports of lower rates of depression (Hallstrom & Persson, 1984), and a lessened likelihood of a diagnosis of major depression (Spendlove et al., 1984). When God’s path is blocked or thwarted, whether by pre-established habit patterns or conscious choice, the depressive response is processed on an insidiously, destructive, multiplying pathway.

Many details of the HCM (Armentrout, 1995; Armentrout, 2000) need to be examined more closely, but the model itself has held up well in the light of current research. I have focused here on the central facets of the HCM, yet there are a few additional points that warrant highlighting: spiral components, physiology, and vulnerability/intervention.

**Depressive Spiral Components**

The HCM postulates that depression generating feelings, thoughts and behaviors interact, producing more events capable and sufficient to elicit a depressive response, an idea supported by Gut’s (1989) description of the interaction among thoughts, emotions and behaviors. This response, in turn, is processed on the aberrant pathway, building the depression-breeding spiral.

Cognitive-behavioral interventions have proven effective in the reduction of these component elements (Evans et al., 1992; Jaycox, Reivich, Gillham & Seligman, 1994; Seligman, Schulman, DeRubeis & Hollon, 1999; Freres, Gillham, Reivich & Shatte, 2002; Resick et al., 2002), with a number of specific cognitive factors identified. These include self-focus (Mor & Winquist, 2002), decreased (positive) self-serving attributions (Ingram et al., 1987), hopelessness and negative explanatory style (Seligman et al., 1999), excessive negative self-relevant automatic thoughts and the minimization of positive experiences and maximized negative experiences (Ingram et al., 1987) and rumination (Mor & Winquist, 2002). Silverman, Silverman and Eardley (1984) reported recovery from depression to be associated with a reduction in maladaptive thinking, with those recovered from depression having less maladaptive thinking than non-depressed controls. Other specific improvements involving spiral components include guilt feel-
ings (Resick et al., 2002) and dysfunctional attitudes, hopelessness and explanatory style (Seligman et al., 1999). Thus, we see that changes in the spiral components decrease the spiral and the concomitant experience of depression.

The Physiological Component of Depression

The HCM asserts that we are spiritual, psychological and biological beings and that all three elements must be addressed in the alleviation and prevention of depression problems. The biological aspects of depression and their importance in intervention and resilience-building have been addressed elsewhere (Armentrout, 1995 and Armentrout, 2000), but the effects of hormones (Desai & Jann, 2000) and neurochemical disturbances (Griffiths, Ravindran, Merali & Anisman, 2000) cannot be ignored and continue to play an important role in intervention in the destructive depressive spiral. But assertions such as “the foundation of treatment is pharmacotherapy, in particular with serotonergic antidepressants (for Dysthymia), although response is moderate at best” (Sansone & Sansone, 1996) are, at their least, simplistic and categorical, and at their worst, misleading and not reflective of a growing body of evidence. In particular, the buffering effects of spirituality, as reviewed here, need to be considered, as do psychological interventions in the spiral. Hollon et al. (1992) found that cognitive therapy and pharmacotherapy did not differ in terms of symptomatic response, either in primary statistical analysis or in the secondary analysis that was restricted to more severely depressed patients. Earlier, Beck, Hollon, Young, Bedrosian and Budenz (1985) demonstrated no difference between cognitive therapy and antidepressant medicationists (for Dysthymia), although response is moderate at best” (Sansone & Sansone, 1996) are, at their least, simplistic and categorical, and at their worst, misleading and not reflective of a growing body of evidence. In particular, the buffering effects of spirituality, as reviewed here, need to be considered, as do psychological interventions in the spiral. Hollon et al. (1992) found that cognitive therapy and pharmacotherapy did not differ in terms of symptomatic response, either in primary statistical analysis or in the secondary analysis that was restricted to more severely depressed patients. Earlier, Beck, Hollon, Young, Bedrosian and Budenz (1985) demonstrated no difference between cognitive therapy and antidepressant medication, and that the addition of tricyclic medication did not improve the response produced by cognitive therapy alone. Further, in a two-year follow-up study of patients who had responded to either cognitive therapy, pharmacotherapy or the two combined, the number of patients relapsing was significantly higher for pharmacotherapy than either of the two cognitive therapy groups (Blackburn, Eunson & Bishop, 1986). And finally, patients treated with cognitive therapy, alone or in combination, had less than half the rate of relapse shown by patients whose antidepressant medication did not continue past the acute episode, and the rates did not differ from those continued on medication (Evans et al., 1992). This, in terms of the HCM, makes a great deal of sense in that medications effectively treat the physiological aspects, or the degree, of the spiral, but do not impact either the spiritual, cognitive, or behavioral patterning that are multiplicative in the spiral. Thus without reducing or eliminating the generative components, the spiral would be expected to self-sustain and continue to breed depression.

Implications for Intervention And Prevention

As we have seen, scripture has provided us with an effective framework for understanding and dealing with depression, and the HCM, based on scripture, stands up well to the findings of scientific investigation. What then are the implications for future work? First, as Ruscio and Ruscio (2000) noted, the fact that the structure of depression is dimensional, in itself, alters our theories and interventions. Add to this the motivational and spiritual dimensions and the two tracks of depression, our intervention successes to date become more understandable and alternatives for both intervention and prevention are expanded. With depression being dimensional, interventions, both preventive and restorative, can be designed more specifically for where they fall on the depressive response pathways. Special vulnerabilities have been identified (Silverman et al., 1984; Post, 1992) and Sandler (1999) recommended that strategies take advantage of optimal occasions. For example, Cicchetti and Toth (1998) postulated what they call depressotypic developmental organizations (pathological organization between the cognitive, socioemotional, representational and biological domains within depressed individuals that may eventuate in depressive disorders across the life course) originating in infancy, and others (Hankin et al., 1998) reported peak gender differences increases in depressive symptoms occurring between the ages of 15 and 18, making this another logical target for designed interventions.

The pioneering cognitive-behavioral prevention program of Martin Seligman and his co-workers underscores the need for such targeting. They reported that among their high-risk population, participants with more pre-workshop depressive symptoms on the Beck Depression Inventory had a greater prevention effect than those with fewer symptoms (Seligman et al., 1999). They further found that this form of intervention was not as successful with severe levels
of depression, but was more successful with moderate levels. In a younger population of school children, Jaycox et al. (1994) found symptom reduction to be most pronounced in those children who were most at risk.

An additional set of factors makes these findings even more important. Those who work with the depressed find ourselves at the nexus of pressure from restricted resources imposed by financial limitations and insurance-governed care where it abuts with the rising tide of depression. Our interventions simply have to change, and as described, the HCM opens possibilities. While there certainly will continue to be a need for effective restorative intervention, the HCM, and relevant research, point us toward interventions that have the promise of reducing both the human and fiscal burdens of depression, the use of targeted population prevention strategies and prophylactic skill training.

One final note is of importance. Dueck (2002) said, “The conversation between theology and psychology resembles a Babel of cultures, languages and ways of thinking—as it should be” (p. 79). The prevention studies cited here were predominantly cognitive-behavioral in orientation, and may have implied that an effective solution to the depression problem will come primarily from this domain. Nothing could be further from the truth. To meet the challenge of burgeoning depression, Dueck’s eloquent description will need to be expanded to include the medical and biological cultures as well as the numerous subcultures within the psychological and theological domains. The basic structure of the HCM of depression has drawn support from findings of a spectrum of theoretical perspectives. As we develop new strategies for prevention and treatment, it is clear that it will require the insights of interpersonal as well as cognitive-behavioral approaches, and recognize the importance of the theology of deliverance and forgiveness as well as the function of neurotransmitters and genetic predisposition. To settle for less would condemn us to the fate of the fabled blind scholars, whose study of the elephant, piece by unassociated piece, rendered all their findings irrelevant and ineffectual. The HCM of depression provides at least one scriptural-founded template that integrates the contributions of diverse approaches and offers significant promise in the understanding, treatment and prevention of depression.

Notes

1. The reader is referred to Benner (1998) for a thorough discussion of the comparative nature and definition of spirituality, religious spirituality and Christian spirituality.

2. The Christ-softened heart refers to the healing and cleansing that takes place post-salvation. This transforming process “softens the heart” of the believer in the sense that they become increasingly aware of things within themselves that are offensive to God’s spirit and are likewise increasingly sensitive to the things that are not of God that are in the world around them. This would include the pain, suffering and sin of others.

3. The finding that those with religious underpinnings (in this case Christian) actually had more severe initial symptoms than those without such belief when loss was essentially equal raises interesting questions for further investigation. First, it is strong evidence that the destructive course of depression does not represent only intensity of symptoms (quantity), but that there are also qualitative differences or possibly an interaction of some type involved. Second, it points to the fact that the relationship of spiritual belief (such as Christian belief vs. Atheism) and depression is not simple. Christians can and do get depressed. Atheists can process their “Heart Cry” (forgiveness, rest, etc.) on God’s path with no knowledge of the Designer. But the HCM would predict quicker and more complete resolution for those with both a relationship with God and a knowledge of God’s tools.

References


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