MAJOR DEPRESSION IN WOMEN

By Jodie Brown

"As the deer pants for the streams of water, so my soul pants for you, My soul thirsts for God for the living God, When can I go and meet with God? My tears have been my food day and night, while men say to me all day long, Where is your God?....Why are you downcast, O my soul? Why so disturbed in me? Put your hope in God. For I will yet praise him, my Savior and my God. My soul is downcast within me, therefore I remember you....." ***Psalm 42:1-7***

Contents

Acknowledgements

I thank God for enabling me to collect and put information together. Without him it would be impossible to know where to begin. I thank him for carrying me through the hard times as I undertook this project.

I thank God for close Christian friends whom gave me the encouragement to keep on persevering in times of anxiety and stress in doing this review. Their prayers were much appreciated.

I particularly thank a close Christian friend, Amanda whom was responsible for editing and assisting with assignment structure. This was much appreciated.

I thank God for providing the support and encouragement from small group peers and tutor throughout doing this assignment.

Introduction

The world is rapidly changing. It's become increasingly busy and stressful place. People are forced to keep up with the race of living, as they try to balance their many life responsibilities.

The roles of the women and men in our society have changed. Women are now spending more time outside the family. Some women choose not to marry and give life to having a career. Others have been in broken relationships or have never found their life partner. Whether married, divorced, single-parent and never married women are often balancing work, studies, marital/family and financial responsibilities. The physiological and emotional uniqueness of women affects their ability to manage stress and carry out their life. They may lack the family, emotional and social support to help them to cope.

With the balancing of various responsibilities is the confusion in the gender roles. Women's role was once seen to be purely to support husband and nurture children. With women balancing different roles they are losing a sense of their identity and purpose in living. In an attempt to develop their identity women try to find a sense of satisfaction and fulfilment in their work. With loss of identity and increased stresses there is an increased sense of despair and hopelessness. The incidence of Depression in women is on the rise. Many women are becoming diagnosed with Major Depression. Major depression is different to general depression based on clinical pathway. This problem needs to be addressed by society, families and health professionals. It is the purpose of this review to examine the topic of Major Depression in women over the age of 18 years.

In the first section of the review there will be a discussion of the definition, distinguishing between 'normal' definition and Major Depression. The incidences, possible causes and/or risk factors, characteristics and spiritual aspect of Depression will be examined. In examining possible causes and/or risk factors there will be an examination of theories around Depression. This will later assist in an understanding of the management of Major Depression.

Within second section of the review there will be exploration and analysis of various therapy issues; crisis management, medical, medication, nutrition and alternative treatments, exercise, relaxation, journaling, cognitive therapy, assertiveness training, building self-esteem and family therapy.

The aim will be to gain a holistic view of Major Depression and its management. It is important to note that information has come from both secular and Christian material. As this topic of Major Depression in women is quite specific information has been obtained from sources on general depression, Major depression of non-gender specific and gender specific.

Definition

Many people may think of Depression as being sad or feeling down emotionally. Some may feel person needs to "snap' out of it. It may be seen as a weakness. Or it may be seen as mental illness requiring medical treatment. Everyone has own way of defining depression, based on understanding of what it is. This may be based on our education, life experience and exposure to people with depression and/or having had depression themselves.

Depression is broad term for feelings of deflated emotions. This is a common and normal experience for people. [1] However, Major Depression is significantly different to 'normal' depression experienced by women.

In order to gain clear a definition of Major Depression various source of information will be examined.

Firstly, Depression was formerly referred to as Major depression, Major depressive disorder or Clinical depression. It is seen as mental illness. It involves mind and body affecting person's thinking and behaviour. It causes a variety of emotional and physical problems. [2]
With increasing understanding of possible causes and severity of the Major Depression there has been seen to be a difference between person having 'normal' depression and Major Depression.

World health organisation points on a Major depressive episode, being distinguished from 'normal' depression, based on severity, persistence, duration and the presence of characteristic symptoms. It is called an Affective disorder. [3]

DSMIV-TR categories Major Depression as are Mood disorder. It is based on having a Major depressive episode. The essential characteristic involves;
"a period of at least two weeks during which there is either a depressed mood of loss of interest or pleasure in nearly all activities.[4]

- Four additional areas - affect physical, mental and emotional well-being. i.e. changes in appetite, weight, sleeping, psychomotor activity, low energy, feelings of worthlessness/guilt, thought process problems, recurrent thoughts of death or suicide, plans and attempts.
- Symptoms - Uni-polar - not Mixed episode i.e. bipolar
- Symptoms - persist most days, nearly every day, two consecutive weeks.
- Clinical significant distress or impairment - social, occupational or other areas of functioning
- Symptoms - not from direct physiological effects of substance (i.e. drug abuse, medication) or general medical condition.

---

[1] Blackdog, 2007 <http//www.blackdog institute.org.au/depression> (viewed 1/3/08)
[2] Mayoclinic, 2008 <http://www.mayoclinic.com/print/major depression> -(viewed 20/9/08)
[3] World Health Organisation, 2004, Management of Mental health disorders, Sydney, World health organisation p145
[4] American Psychiatric Association, 2000, DSM –IV-TR, Arlington p349

- Symptoms - not based on bereavement i.e. loss of loved one, except if persist longer than 2 months or have marked impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation. [5]

Major depressive episodes may occur once, twice or several times.[6] With criteria of Major depressive episode met person may have Major depressive disorder.

According to DSMIV-TR Major depressive disorder is;

- clinical course characterised by one or more Major depressive episodes
- Without history of Manic, Mixed, and Hypo-manic episodes
- Without episodes of substance-induced Mood disorder; due to direct physiological effects of a drug of abuse, medication or toxin exposure or Mood Disorder due to General Medical condition
- Not accounted by Schizoaffective disorder, Schizophrenia, Schizophreniform disorder, delusional disorder or psychotic disorder not otherwise specified. It can be seen to be of single or recurrent episodes. [7]
- With full criteria for Major depressive episode met person is categorised into different groupings
- Mild – about 4-5 symptoms. Cope with most everyday activities. Minor impairment in occupational and social functioning.
- Moderate – about 6-7 symptoms. Difficulty coping with completing everyday activities. Significant impairment in occupational or social functioning.
- Severe without psychotic features – about 8-10 symptoms. Most symptoms. Marked impairment in symptoms and everyday activities. Somatic features.
- Severe with psychotic features - presence of either delusions or hallucinations, typically auditory. [8]
- Chronic – meets criteria for depressive episode at least two years.
- Catatonic - at least two of features i.e. motor immobility; catalepsy or stupor, excessive motor activity, extreme negativism, or becoming mute, peculiarities of voluntary movements, stereotyped movements, prominent mannerisms and facial expression, repeat other words or imitate them. [9]
- Melancholic - loss of pleasure, activities or lack reactivity to pleasure. At least three features; distinct quality of depressed mood, depression worsens in morning, early morning wakening, psychomotor retardation or agitation, anorexia or weight loss, excessive guilt or inappropriate guilt. [10]
- Atypical features - mood reactivity, Includes presence of at least two; increased appetite or weight gain, excessive sleep, leaden paralysis, long standing pattern of extreme sensitivity to perceived interpersonal rejection.
- Post-partum onset – after childbirth. [11]

[5] DSMIV-TR, p356
[6] ibid. p349
[7] ibid p369
[8] WHO, p147
[9] DSMIV-TR, p418
[10] ibid, p419
[11] ibid p420

Incidence of Major depression

Major depression has become increasing problem. Women have a greater risk of developing Major depression than men. In fact it has been seen in studies that depressive episodes affect twice as many women than men. [12]

According to DSMIV- TR (2000) lifetime risk of Major depressive disorder from community samples varies from 10-25% for women. It is 5%-12% in men. Point prevalence has varied in community samples from 5-9% for adult women. It is 2%-3% in men. Young people have highest level of Depression with 5% being affected. 20% of them will have Depression as adults. [13]

The statistics show that the rates of Major Depression in women are higher than in men.
It is however difficult to obtain accurate statistics between males and females. Women generally are seen to more likely seek out treatment for depression and therefore become diagnosed with Major Depression. [14]

Causes of Depression

Scientist and other researchers have developed various theories about what may contribute to Depression. Health professionals, including Medical practitioners, Psychiatrist, Psychologists, Nurses, Social workers and/or counsellors develop own views. Social theorists and/or other researchers have different theories.

Despite many views there really is no known cause. What is known is that there are a variety of possible factors that may lead to a person having a greater chance of becoming depressed. [15]

It is the purpose of this section to explore some possible factors contributing to major depressive episodes, leading person to be diagnosed with Major Depressive disorder.
In examining factors there will be special reference to those specifically related to women.

Mayoclinic mentions three factors thought to contribute to Major Depression. These include;

- Biochemical
- Genetic
- Environment. [16]

<u>Biochemical factors</u>
There are various theories around biochemical factors that contribute to Major Depression based on studies that have been done by various researchers.

[12] DSMIV-TR, p 354
[13] ibid p 372
[14] Mayoclinic
[15] ibid
[16] ibid

According to DSMIVTR it is not possible to diagnose Major depressive episode based on laboratory findings. However, a variety of laboratory findings have been abnormal more often in persons with major depressive episodes compared to controlled groups. These are often in melancholic, psychotic features and severely depressed persons.
The laboratory findings include;

- Sleep EEG abnormalities - 40-60% outpatients, up to 90% in inpatients with depressive episodes. Sleep continuity disturbances i.e. intermittent wakefulness, early awakening etc [17]
- Physical changes in brain – alterations in cerebral blood flow and metabolism being increased to certain parts of brain and decreased to other areas. Depression later on in life - contributes to alterations in brain structure. [18]
- Brain chemicals – theories based on imbalance of chemicals messengers (neurotransmitters) Serotonin, Norepinephrine, Dopamine, acetylcholine and gamma-aminobutyric acid (GABA). Serotonin - involved in inducing sleep, sensory perception and control of mood. Norepineprine - maintaining arousal from deep sleep, dreaming and regulation of mood. Dopamine - involved in emotional responses. Acetylcholine - released to lead to excitation. GABA - restraining of impulses. [19] Theories about Depression - based on low levels of serotonin and norepinephrine. [20]
- Imbalance of hormones – Various theories include;
- - Alterations of several Neuropeptides (group of transmitters) [21] consist of amino acids naturally occurring in brain. Some function as neurotransmitters, however, mostly involved in modulating response of or to neurotransmitters. Endorphins - one type which acts as painkiller. [22]
  - Elevation in glucocorticoid secretion and blunted growth hormone, thyroid-stimulating and prolactin responses. [23]
- Other theories involve other hormones and neurotransmitters.
  * High level of stress hormone Cortisol - thought to block GABA, resulting in increased anxiety and risk of Depression. [24]
  * Prostaglantin-E2 - reduce release and uptake of neurotransmitters in brain, such as, serotonin. Depressed person - 2-3 times higher level of hormone. [25]

There are many different biochemical theories on Depression. It may be likely that these changes in brain, imbalances in neurotransmitters and/or hormones may lead to a person becoming depressed. Yet, still there is no definite evidence for

[17] DSMIV-TR p. 352
[18] ibid 353
[19] Tortora, G and Anagnostakos, 1990, Principles of anatomy and physiology, New York, Harper and Row., p406-7
[20] Davidson and Neale, 1990, Abnormal Psychology, John Wiley and Sons, New York p.
[21] DSMIV-TR p.353
[22] Tortora, p408-409
[23] DSMIV-TR, p353
[24] Hart, A and Hart Weber, C, 2007, A Woman's guide to overcoming Depression, Grand rapids, Spire p55
[25] Litchfield, B and N, 2006, Christian counselling and family therapy, Volume 4. Canberra, Litchfield Family Services p120

this. To gain a balanced view there needs to be further examination of the factors that may contribute to depression.

Genetic factors:
Some studies have shown Depression is more common in persons with biological family members with condition. Researchers have attempted to find gene that may be related to Depression. No gene has been found. [26]

Blackdog Institute points out genetic risk of Clinical depression is approx. 40%. Therefore 60% is thought to be due to environmental factors. [27]
Hart believes increase risk of depression in families is due to genetic vulnerability, family relationships and socialisation. [28]

It is obvious that there is no absolute evidence that genetic factors lead to the development of Depression although there is evidence of a hereditary link. This means further investigation is required. The affect of the environment on person needs to be considered as well.

Environmental factors:
Environmental factors have been thought to affect onset of Depression. These include situations in person's life making life difficult to cope. [29] These will be further explored in discussing risk factors.

Risk factors:
There are some factors that may increase risk or triggering Depression. These include;

- Having biological relatives with depression
- Having family members that have suicided.
- Stressful life events
- Depressed mood as younger person
- Illness i.e. cancer, heart disease, Dementia, CVA
- Long-term use of certain medications i.e. birth control pills, hormone treatments
- Personality traits i.e. low self-esteem, co-dependence
- Alcohol, nicotine and drug abuse – it may be difficult to determine which comes first
- Recently given birth
- Lower socioeconomic group [30]

[26] Mayoclinic
[27] Blackdog
[28] Hart, p55
[29] Mayoclinic
[30] Ibid

In examining risk factors there will be a grouping into biological, psychosocial, relationship and mental/cognitive. This will allow for Depression in women to be further explored.

Biological risk factors unique to women:

These involve reproductive cycle and alterations in female hormones. Different reproductive related events affect hormonal balance. These include;

- Premenstrual syndrome (PMS)
- Menopause and climacteric
- Postpartum syndromes (PPD)
- Other reproductive related events i.e abortions, infertility [31]

Hart suggests Depression in women has been linked to balancing of female hormones. This involves mood altering hormones; oestrogen and progesterone. These may affect emotional status and increase risk of Depression. [32]

Mayoclinic indicates exact interaction of Depression and premenstrual syndrome is unclear. Some researchers think it may be related to cyclical changes in oestrogen, progesterone and other hormones, disrupting brain chemicals functions controlling mood. Depression in post-menopause women relate to reduction in oestrogen. However, other factors need to be considered. In pregnancy, women may be affected by changes in relationships, social support, mixed feelings about pregnancy, miscarriage and unwanted pregnancy. [33]

Hart states studies have shown that clinical depression is not an inevitable consequence of menopause. Hormonal changes affect peri-menopausal symptoms. Other factors; include 'empty nest", midlife crisis and marital problems. [34]

It is obvious that reproductive-related events can affect women mood and behaviour. However, it is difficult to determine whether female hormones play a part in onset of Depression. It is necessary to take them into consideration. However, other psychosocial factors need to be considered.

Psychosocial factors:

There are many psychological and social factors affecting woman developing Depression. Some will be discussed.
Stressful life events triggering Depression include;

- Relationship breakdown
- Change of job
- Family problems
- Financial difficulties
- Illness and death

[31] Mayoclinic
[32] Hart, p 56
[33] Mayoclinic
[34] Hart, p 130

- Prolong periods of anxiety may make a person vulnerable to feeling emotionally flat. Excessive stress will lead to feeling helpless and hopeless. [35]

Hart believes psychosocial factors may affect onset of Depression. These include; early childhood problems e.g. abuse, family dynamics and Mother of young children, poverty, minority status and urban dwellers. [36]

Litchfield questions whether chemical imbalance is cause of Depression or result of Depression. They suggest chemical imbalance may be affected by other factors. Psychological factors include; guilt, anger, rejection, disappointment, low-self-esteem, and frustration in reaching goals and social factors; loss of job and spouse. They make reference to Freud's psychodynamic theory of Depression based on anger being turned inward. [37]

It can be seen that women are affected by many different psychological and social factors. They are certainly affected by their environment and stresses in life. These may increase anxiety levels and chances of developing Depression. Psychological factors, different emotions may also be seen to contribute to Depression. There needs to be a consideration of these factors in increasing stress levels and likelihood of Depression.

Relationship factors

Often women's role is to provide emotional support and nurturing for spouse, children and other family members. This can cause increase stress and chance of developing Depression. The emotional support received from husband will affect stress levels. Other relational factors need to be considered.

Beckham believes quality of marriage relationship impacts on ability of women resilience to stressful life events. Lack of intimacy and emotional support in marriage is seen to affect vulnerability to Depression. [38]

Hart suggests certain relationship factors affect onset of Depression in women. These include;

- low self-esteem
- social and role pressures
- marriage and children
- singleness and single parenting
- Attachment losses.
- Sexual abuse or rape. This can lead to low self-esteem, sense of helplessness, self-blame, and social isolation. These are seen to be possible causes of Depression. He includes physical abuse. [39]

[35] Tanner S, and Ball, J, 1991, Beating the blues: A Self-help approach to overcoming Depression, Southwood Press p18-22
[36] Hart p53
[37] Litchfield p 120
[38] Beckham, E and Leber, W, 1995, Handbook of Depression, 2nd edition, New York, The Guildford Press. p 406

Women sexually abused as children have significant higher incidence of Depression. Abuse can cause lower self-esteem, self-blame, low self-esteem, shame and feelings of worthlessness. [40]

Women are generally more relational than men. This means that women can be more vulnerable to Depression based on relationships. They are affected by marital, family and other relational issues. These can increase the chances of a women developing Depression.

Mental and cognitive factors

Women may be affected by thinking patterns and personality style.
According to theories cognitive processes play important role in emotional status. Some cognitive theories believe anxiety, thoughts and beliefs affect emotional state of person.
Aaron Beck's cognitive theory of Depression points out Depression and thinking are correlated. [41]

Phillips believes thinking, perceptions and emotions affect chemicals imbalance and lead person to becoming depressed. [42]

Women personality styles and psychological makeup affecting onset of Depression;
* Passive, co-dependent, pessimistic, lack control of stressful events, become overwhelmed by stress.
* Melancholic personality - deeper capacity for feeling, sometimes pessimistic.
* Women respond to stress differently to men. They are seen to be inward thinking and ruminate over problem. This can result in pessimistic and negative emotions. [43]

It is obvious that the woman personality and way of dealing with stress may have huge affect on mental well-being. The woman with Depression struggles with negative and irrational thinking patterns. Whether it is the cause or the result of Depression is the question. It is difficult to conclude that thinking patterns alone are the cause of depression however they may play a part in contributing to Depression.

In summarising this section, it can be seen that it is not possible to know exactly what causes Depression in women. Given the complexities of women it is necessary to consider a variety of interactional factors that may lead to increased risk of a woman becoming depressed and therefore developing Major Depression. These include internal, external and psychosocial factors. This will assist in a greater understand of managing a women with Major Depression.

---

[39] Hart p59-61
[40] Beckham, 558-9
[41] Davidson and Neale, 1990, Abnormal Psychology, John Wiley and Sons, New York p227
[42] Phillips, B, 2007, Overcoming Anxiety and Depression: Practical tools to help you deal with negative emotions, Eugene, Harvest House Publishers p 76
[43] Hart p 62

Characteristics of Depression

To determine specific characteristics of Major depression reference to DSMIV-TR is made. These include the following;

- Loss of interest or pleasure - Some people - reduced sexual pleasure or desire. Withdrawing or neglect of pleasurable activities.
- No feelings, feeling "blah" or anxious.
- Depressed mood – observed in facial expression and demeanor.
- Appetite - reduced, force self to eat or increased appetite and food cravings i.e. carbohydrates and refined sugars.
- Increased irritability i.e. persistent anger, respond with angry outbursts or blaming others or exaggerated sense of frustration over minor matters.
- Sleeping problems – Insomnia - waking up at night, difficulty getting back to sleep, waking up too early. Oversleeping less likely - prolonged sleep at night and daytime.
- Psychomotor changes – Agitation - inability to sit still, pacing, hand-wringing, pulling, rubbing skin. Retardation - slowed speech, thinking, and body movements, increased pauses, decrease volume of speech, amount, variety and content.
- Decrease energy, tiredness and fatigue - fatigue without physical exertion. Efficiency with certain tasks reduced.
- Sense of worthlessness or guilt – Unrealistic and negative self-evaluations, guilt preoccupation, self-blame, delusions or negative about self.
- Impaired ability to think, concentrate or make decisions. - Easily distracted, memory problems.
- Thoughts of death, suicide ideation or attempts – Feel 'better off' if dead. Recurrent suicide thoughts and plan to suicide. Variable in frequency, intensity and severity. [44]
- Other associated features and disorders
  - tearfulness, irritability, obsessive thoughts/behaviours, anxiety, phobias, excessive worry over physical health, complaints of pain.
  - Panic attacks, meeting criteria for Panic disorder.
  - Difficulties in intimate relationships, less satisfying social interactions
  - Sexual difficulties
  - Marital, occupational and academic problems,
  - alcohol, other substance abuse, increased use of medical services.
  - Suicide high with psychotic features, history suicide or concurrent substance use.

  [45]

Many assessment tools exist for health professionals to identify with characteristics. These include; DSMIV-TR, K10, SPHERE, DASS and BDI.

Assessment may involve psychiatrist assessment, mental and/or general medical assessment. General medical assessment i.e. blood and other tests to rule out organic causes for Depression. (Refer to Appendix for assessment tools)

[44] DSMIV-TR, 349-350

[45] ibid p352

Is Depression a sin?

This question has certainly been a controversial one within different Christian circles over the years. Different Christian groups or individual Christians hold various views based on their understanding of Depression, God's word and own experience.
Some views that are held by different Christians include;

- Depression is a result of sinning against God or others.
- We live in a broken world that has been affected by original sin. We experience the effects of disease and illness. Depression is an illness caused by this brokenness.
- Depression is result of combination of sin and effects of living in broken world.

Can sin led to Depression?

Sin is rebellion from God or going against what God commands. (Romans 3:9-18) It involves attitudes, thoughts and actions. Sin is seen in many different ways. i.e. unbelief in God, disobedience and laziness as Christians. It is seen in man's sinful nature i.e. unforgiving, lustful thoughts, fits of rage, sexual immorality, hatred, pride and envy, greed, drunkenness, pleasure seeking, self-pity and self-centredness. (Galatians 5:19-21) When sin is not confessed to God and unresolved things are held onto there can be a feeling of guilt due to conscience and the Spirit convicting person of sin. True guilt and resulting shame can lead to feeling depressed.

According to Phillips unconfessed guilt can lead to fear and anxiety, which ultimately leads to Depression. He suggests that person needs to take responsibility for thoughts, words and actions, and go through steps of working towards reconciliation in relationships. He holds view that Depression can be caused by our sinfulness. (Phillips, p191-3) [46]

A great example of this in bible involves Cain. He became angry at God for not taking his offering. This led to jealousy towards his brother Abel and ultimately led to depression. The Lord questioned his sin "Why are you angry? Why is your face downcast? If you do what is right, will you not be accepted? But if you do not do what is right, sin is crouching at your door; it desires to have you, but you must master it?" (Genesis 4:2-16) Cain became depressed due to sinning against God.

Is Depression always a result of our sinfulness?
In the beginning God created a perfect world for people to live in. He created man and woman to live in perfect relationship with him and each other. (Genesis 1) Sadly enough this scene changed. There was the 'fall of man'. Adam sinned against God. He blamed Eve for causing him to sin. Eve sinned against God and blamed Satan for causing her to sin. They had a broken relationship with God and one another. They continued to rebel against God in thought and actions. (Genesis 2) Since 'fall of man' people became sinful.

[46] Phillips, p191-193

As a result of original sin there is no longer a perfect world. The world is broken with broken people. People are affected by own sinfulness, other people's sinfulness and the consequences of original sin. The effects of sin can be seen in our sinful thinking, attitudes and behaviour, broken relationships, loneliness, grief and losses, stress-related conditions, mental illness, disease and death. As fallen man people sin against each other and God.

Depression may be a result of own sinful behaviour. On the other hand, Depression can be seen to be a result of living in a broken world with broken people.

Is it sinful for women to have Depression?

God made women for relationships. He made them to have a good relationship with him. Women were also created to have relationship with man and other women. However, as a result of being fallen people and having effects of original sin women no longer have these good relationships. They are affected by broken relationships, loneliness of being single, grief of being without children, financial problems, and balancing roles and stressful life's in being mother, wife, student and/or worker. Not to mention the effects of women's sinful nature. All these things may be factors that contribute to women experiencing Depression.

There is an example of a woman in the bible whom suffered with Depression.
We read about her life story in Ruth. Her name is Naomi. She was a Moabite and had a relationship with God. Naomi became a widow. (Ruth 1: 1-6) Naomi had suffered from the grief of losing her husband and two sons. She suffered emotionally and had Depression for 10 years. She experienced effects of living in broken world; despair, grief/loss, and loneliness, and financial problems. Her long-term dream of living with her family in the country of Moab was lost. Naomi had times of feeling self-pity about her situation in life. She was unable to shake off feelings of depression and become angry with God for causing her problems. She even questions God's sovereignty. (Ruth 1:11-20) Despite feeling upset with God at times she continued in relationship with him.
Was Naomi's Depression caused by her sinful feelings towards God? Or was her Depression caused by part of being in broken world?
It seems that Naomi's Depression was a result of effects of sin; separation in death and loss/grief. She had "pity parties" and most likely had sinful thoughts in depressed state. However, it seems that Naomi continued to have a relationship with God through her time of Depression. She trusted and grew closer to God through painful experience.

Therapy issues

(a) Crisis management

Most women with mild to moderate Depression are able to manage in the community with the review of their local General Practitioner. However, if Depression worsens through stressful events or crisis person may need further assistance.

They may need psychiatrist treatment, including crisis intervention and/or counselling. Crisis intervention aims to reduce stress levels until a person is able to return to normal level of coping. Crisis intervention involves;

- Temporarily taking over responsibility for the problem
- Remove person from stressful situation. May require brief hospitalisation.
- Lower person's level or arousal by listening, encouraging person to talk about feelings and offer reassurance. Brief course of anti-anxiety drugs may be required.
- Diagnose and treat any mental disorder
- With person's judgment returning to normal, offer counselling and structured problem-solving
- In long term - monitor for development of psychiatrist illness. [47]

Counselling aims to allow person to cope with the stressor. For women it is important to listen to stressful situation, allow ventilation, reflecting back with empathy, making sense of her story, examining dysfunctional coping methods and past coping. [48]

Referral to private psychiatrist, hospital-based psychiatric and/or community mental health service may be required based on;

- Severely depressed or complicated cases
- Melancholic or psychotic features or failure to respond to appropriate treatment
- Risk for suicide or significant reduced level of self-care – An accurate assessment of suicidal risk will need to be undertaken. It will be important for counsellor to be non-threatening, non-judgemental, and empathic towards person. They need to allow them to talk openly and freely about thinking and feelings. [49]
  (See Appendix for suicidal assessment)

Most persons with Depression prefer not to be hospitalised. It is necessary to avoid hospitalisation where possible. Community mental health services with extended hours, crisis teams and other intensive treatment programmes may be used. [50]

Accurate assessment of person's mental status will determine need and/or appropriateness of hospitalisation. It can be difficult to determine whether hospitalization is appropriate for the person. They may be able to be treated effectively or even better outside hospital setting. [51]

Hospitalisation may be necessary. The woman may include;

- Voluntary patient – able to give consent
- Involuntary patient - severely depressed – not able to give consent. Person lacks insight and judgement.
  Mental health Act - mentally ill person needs protection from suicide or serious physical or financial harm and from harm to reputation. Individual needs to be

[47] Davies J, 2003, A Manual of mental health care in general practice, Commonwealth Department of Health and Ageing, Canberra p. 151
[48] Davies p. 152-3
[49] WHO p. 22-23
[50] ibid 154
[51] Mayo-clinic

prevented from causing serious physical harm to other people. Involuntary patient – usually brief period until case is reviewed. [52]

(Refer to Appendix assessment for hospitalisation)

(b) Medical

There medical treatments that have been used for a woman with Major Depression. These include ECT, non-traditional treatments; TMS, VNS, deep brain stimulation as well as hormonal therapy. There has been seen to be some benefits and limitations in treatments.

Electroconvulsive therapy (ECT)

Treatment involves electrical current being passed through the brain to trigger a seizure. ECT is administered by psychiatrist and anaesthetist, applying electrical leads to scalp.

Benefits of ECT:

WHO believes treatment is most effective in many cases;

- Depression with Psychotic symptoms
- Depression with Somatic (melancholic) symptoms
- Person has previous positive response to ECT
- Treatment failure with several medications or combined medication and psychotherapy treatment trials
- Need for rapid improvement of suicidal or refusal to eat
- Medical contradictions to medications
- Safest, most effective medical treatment for Major Depression.
- More rapid in effect than antidepressants. [53]

Blackdog Institute agrees ECT has important, yet small part to play in treatment of person with psychotic and severe melancholic depression with high suicide risk, person too ill to eat, drink or take medication and severe post-natal Depression. Other benefits include; safe, fast and not too unpleasant for person, as uses anaesthetic in application of treatment. [54]

Despite many benefits of ECT for some people with Major Depression it is not known actually how it relieves signs and symptoms. It is thought to be responsible for affecting the levels of neurotransmitters in brain, with seizure causing brain to release chemicals. [55]

Limitations of ECT:

Some controversy in the past has been around this treatment. Many people have been sceptical and fearful of ECT, due to possible side effects treatment. Side effects include; headaches, confusion and partial memory loss. [56]

[52] WHO, p154
[53] ibid p157
[54] Blackdog
[55] Mayoclinic
[56] ibid

Despite unknown workings of ECT it is seen to have benefits for many people with Major Depression. It is however not suitable for all people with Major Depression. Given possible side effects and availability of other treatments alternatives need to be considered.

Non-traditional treatments

These are less commonly used and involve direct stimulation to the brain. Mayoclinic mentions three treatments;

- Vagus nerve stimulation (VNS) - electrical impulses used with surgically implanted pulse generator to affect mood centre of brain. Treatment has been approved for certain cases of severe or chronic treatment-resistant Depression.
- Trancranial magnetic stimulation (TMS) - experimental procedure used by neurologists. A coil is held next to scalp and magnetic field created to stimulate relevant parts of brain. TMS is not widely available for use. It has not been approved by FDA for Depression. Clinical research trials are being attended in the US. Used in person suffering with severe depression. Blackdog Institute states it's been used as treatment and diagnostic procedure. Benefits include; no general anaesthetic and no convulsions induced. Limitations include; No evidence for effectiveness. Being researched. [57]
- Deep brain stimulation - highly experimental treatment. Brain is stimulated with surgical implanted electrodes. [58]

Non-traditional treatments are mostly experimental therefore it is difficult to gain an accurate measure of the effectiveness of these treatments against ECT. However, they may be more available in the future for treatment of Major Depression.

Hormonal therapy

This is not likely to be a common treatment. However, it may need to be considered in severe cases of Depression in women. It may need to be used if the woman is not able to function due to depressive symptoms based around reproductive cycle. [59] It may be necessary for some women going through menopause and with severe premenstrual symptoms.

(c) Medication

There are different views on medication in treating Major Depression. Some medical practitioners may prescribe antidepressants and/or other medications without considering other treatments. Others may trial combination of medication, psychotherapy and other natural remedies.

The medical practitioner and psychiatrist often use medical model treating symptoms of person with mental illness. Depression is seen as a mental illness caused by chemical imbalance in the body. On other hand, counselling model

[57] Blackdog
[58] Mayoclinic
[59] Hart, p 125

would manage Depression as mental disorder or malfunction. It believes mental disorder is caused by a build up of stress from many sources.[60] (See Appendix)

The purpose of this section is to explore types, benefits and limitations of medications in treatment of Major Depression in women. In exploring medications various views will be examined.

Medications for Major Depression

There are many different types of antidepressants and other medications. Individual medications are seen to have different functions, benefits and limitations.

- Antidepressants include;
- Selective serotonin reuptake inhibitors (SSRI's) e.g. Zoloft
  - Increase serotonin activity in brain by blocking serotonin re-uptake, increasing serotonin levels and number of serotonin receptor sites. [61]
  - Highly effective without too many side-effects
  - non-sedating
  - safer if person overdoses [62]
- Serotonin and noradrenaline reuptake inhibitors (SNRI's) e.g. Efexor
  - work on balancing serotonin and nor-adrenaline
  - fewer side effects, compared to older antidepressants.
  - effective in Severe depression.
  - safer if person overdoses [63]
- Noradrenaline reuptake inhibitors (NARI's) e.g. Reboxetine
  - Work on noradrenaline in brain improving mood and increasing energy
  - less likely to cause sleepiness or drowsiness [64]
- Tricyclic antidepressants (TCA's) e.g. Clomipramine
  - work on reuptake of serotonin and noradrenaline.
  - act at other receptors - causing side effects
  - very sedating
  - More effective than newer antidepressants [65]
- Monoamine Oxidase Inhibitors (MAOIs)
  - Used when other medications don't work.
  - may require strict dietary restrictions; interact with certain foods, potentially fatal - Newer versions made into skin patches, have fewer side effects. [66]
- Reversible inhibitors of monoamine oxidase –A (RIMAS)
  - Have fewer side-effects and non-sedating.
  - Less effective; in more severe forms of Depression. Help with anxiety. [67]
- Noradrenaline-serotonin specific antidepressants (NaSSA's)
  - Relatively new drug. Helps with anxiety [68]

[60] Phillips, p79
[61] WHO p121
[62] Beyond blue <htp//www.beyond blue.org.au/depression> (viewed 10/07/08)
[63] ibid
[64] ibid
[65] WHO p123
[66] Mayoclinic
[67] ibid
[68] ibid

- There are other medications that may help with Depression.
- Stimulants, mood-altering medications, anti-anxiety medications and anti-psychotics - Combination may be helpful. Some medications are approved whilst others are not, however, effective. [69]
  Major tranquilisers - person with psychotic or melancholic depression, where other medication not helping. [70]

(See Appendix for medications)

Overall benefits of medications include;

- Thought to correct imbalance in chemicals in nerve cells (neurones) in brain. Different types of antidepressants affect different naturally occurring biochemical in brain changing mood. [71]
- Mostly safe – newer medications have less serious side effects and overdose problems.
- Effective in treating Depressive symptoms.
- Non-addictive [72]
- Maybe valuable in responding to counselling, allowing moving out of Depression.
- May be beneficial in severe or recurrent depression, episodes with psychotic, or somatic symptoms, presence of suicidal thoughts, family history of serious depressive illness. [73]

Limitations of medication

These include;

- Takes time to work and symptoms to improve – about 8-12 weeks.
- Side effects - vary from more mild to serious. Serious - increased suicidal thoughts or behaviour, serious or life threatening health problems, such as, liver failure, dangerous drop in white blood cell count. Often rare, yet need monitoring. [74] Older drugs have more side effects, including high blood pressure requiring monitoring. [75]
- Precautions
  Factors include; age, chronic illness, pregnancy and childbirth. Some antidepressants are more sorted to younger person and those with chronic illnesses. Certain antidepressants are more suitable to be taken with other medications. They are not to be taken in pregnancy and taken with caution in breastfeeding child. [76]
- "Poop-out" effect - losing effectiveness over time. Affects approximately 20% of people, Cause is unknown. Some possible suggestions; relapse or worsening of Depression, underlying medical condition, aging, new medication or

[69] Mayoclinic
[70] Blackdog
[71] Mayoclinic
[72] Blackdog
[73] Litchfield Volume 4 p124
[74] Mayoclinic
[75] Blackdog,
[76] ibid

reassessment of original diagnosis. It is however usually possible to counteract the effects by changing medication, dose or adding other medications. [77]

- Treatment Resistive Depression – Some people do not respond to Antidepressants and Psychotherapy. [78]

Is medication enough to manage a woman with Major Depression?

Litchfield (2006) states;
"Antidepressants may adjust certain chemical imbalances in the brain and therefore alter mood but they will not touch the spirit and the root cause. Medication simply dulls the pain"
[79] It seems that antidepressants may relieve some depressive symptoms. However, they may not allow a person to deal with underlying issues.

Litchfield believes counselling needs to be primary treatment for Major Depression.
They recognise there is no evidence to support emotional pain being caused by chemical imbalances. Drug therapy has not been proven to be better than psychotherapy or with combination of medication and psychotherapy. [80]

WHO believes that the best long term strategy for Major Depression is combination of medication, and psychotherapy.[81]

It is obvious that medication may have some benefits for the woman with Major Depression. However, they also have limitations. The woman will need to have psychotherapy alongside
using medication to allow her to work through unresolved issues.

(d) Nutrition and alternative treatments

A woman with Major Depression may lack appetite, loss interest, enjoyment in food, lack energy to prepare food and loss weight. Alternatively she may feel like eating more, especially sweet foods. [82]

Nutritional and alternative treatments may assist women with Depression to improve physical and mental well-being. These include;

- Nutrition and other nutritional supplements
- Dietary supplements; St John's Wort, SAM-e and Omega-3 fatty acids.
- Other alternatives

Nutrition and nutritional supplements

Healthy diet includes;

[77] Mayoclinic
[78] WHO, p152
[79] Litchfield, Volume 4 p121
[80] Litchfield, Volume 4 p124
[81] WHO in Litchfield Volume 4 p180-181
[82] DSMIV-TR, p349

- High intake - wholegrain cereals, fruit and vegetables.
- Moderate intake - protein foods; meats, chicken, eggs etc
- Low intake - fatty, sugary and salty foods.
- Avoid or limit caffeine and/or alcohol
  (See Appendix for food pyramid) [83]

Other nutritional supplements;

- Vitamin B6, Folic acid, Vitamin B12 – moderate, lasting effect on brain chemistry, mood and energy levels. Keeps person from cravings refined foods. Vitamin B6, Folic acid - assist to reduce depression, improves antidepressants. Link between Serotonin availability and Vitamin B6.
- Calcium, Zinc, magnesium, selenium and iron – may prevent Depression, irritability and mood swings. Low magnesium - personality changes, weakness and poor concentration. [84]

Dietary supplements

St John's Wort (Hypericum perforatum)

* Popular herbal remedy, flower; contains chemical compounds.

* Function – Some chemicals – thought to prevent nerve cells in brain from reabsorbing messenger Serotonin or reduce levels of protein for immune systems functioning. Assist reuptake of Serotonin, dopamine and nor-adrenaline. [85]

* Benefits – assist mild to moderate Depression. [86]

Studies – shown superior to placebo or as effective as antidepressants for mild to moderate and non-melancholic Depression. [87]

- Limitations -
  - Unlikely to be effective with melancholic or biological Depression.
  - clinically depressed person less effective than formal antidepressants.
  - dose of active ingredients unable to be accurately controlled. [88]
  - Atypical antidepressant - not known how it works. Ingredients may have broader benefits, unlike that in synthetic antidepressants.
  - Side effects; gastrointestinal irritation, nausea, indigestion, abdominal pains, dry mouth, dizziness, fatigue, increased light sensitivity.
  - Cannot be taken with antidepressants as increases Serotonin to toxic levels. [89]
  - May interact with other drugs, increasing effects of other drugs or impact on effectiveness of other drugs. [90]

SAM-e

Used in Europe; prescription drug to treat mild to moderate depression. Not approved in US or Australia. It is a synthetic form of naturally occurring chemicals

[83] Davies, p238
[84] Hart, p182-183
[85] Blackdog
[86] Mayoclinic
[87] Blackdog
[88] Ibid
[89] Hart, p175
[90] Blackdog, 2008

in brain. SAM-e supplement - results in increased activity of serotonin and dopamine, fluidity in cell membrane. Responsible for improve person's mood. [91]

Omega-3 Fatty acids

In some people with Depression there is link between Depression and lack of Omega-3 fatty acids; polyunsaturated fats mostly found in seafood. Omega-3 - integral components of brain's cellular membranes; including synapses for chemical exchange. A long chain of omega-3 fatty acids protect nerve cell membranes in brain. Omega-3 allows optimal composition of nerve cell membranes. Low levels of omega-fatty acids affect enzyme which breaks down serotonin, epinephrine and dopamine. [92]

Research shows imbalance in ratio of EFA's, namely omega-6 and omega-3 fatty acids and/or deficiency in omega-3 fatty acids may be responsible for heightened depressive symptoms. [93]

Omega-3 has an important part to play in affecting mood-altering neurotransmitters in brain. This can affect person's mood and increase chances of depressive symptoms.

Other alternatives
Ginko biloba – improve blood supply to brain and mental functioning. Natural antidepressant; has Serotonin enhancing effect, normalising levels.
Kara root - beneficial in treatment of anxiety disorders, often with Depression. It is unknown how it works.
Valerian root - has sedating effects and mood stabilising functions. Calm anxiety, nervousness, high anxiety Depression and relieve insomnia. [94]

Blackdog Institute states that biological types of depression, melancholic and psychotic Depression will be unlikely to respond to self-help and alternative therapies alone. However, they may be valuable adjuncts to other physical treatments. [95]

There is some controversy regarding benefits of nutritional supplements amongst researchers and health professionals. The women with Depression may benefit from having balanced diet, dietary and nutritional supplements as required. However, these need to be used with other treatments.

(e) Exercise

Women with Major Depression have varied levels of physical ability, depending on severity of depression. The woman with moderate to severe Depression may not

[91] Hart, p179
[92] Hart, p181
[93] Rao
[94] Hart, 177- 8
[95] Blackdog

feel like exercising. Therefore they need to build themselves from light to moderate activity. They will need to see benefits for exercising.

Exercise and Depression:

Beyond blue agrees exercise allows for less symptoms of Depression. Persons attending activities of light or moderate level leads to 50 % reduction in symptoms of depression and anxiety. Cycle of depression can be broken in doing pleasurable physical activities. [96]

Studies showed exercise may be third alternative to antidepressants. It is immediate and has long-term effects. Exercise was seen to be equally effective for both genders. Aerobic and non-aerobic were effective in decreasing Depression. The greater length of time on exercise programme and sessions decreased Depression. Most powerful antidepressant effect occurred with combination of exercise and psychotherapy [97]

How does exercise work?

There are different views on reasons exercises assists person with Depression.
These include;

- Biochemical - seen to reduce excessive adrenaline in the body.
  Adrenaline - strong component in anxiety and various forms of arousal.
- Increases the body's production of endorphins. Endorphins - bodies own form of morphine. These reduce pain and seem to create an overall sense of well-being.
- Releases emotional frustrations and relaxes muscles. [98]
- Increases neurotransmitters i.e. dopamine and nor-adrenaline.
  Increase fitness may improve mood and mental focus. [99]

Benefits of improving activity levels:
There are many benefits;

- Gives greater sense of control of life.
- Distracts person from problems and negative thinking.
- People become less tired.
  Inability - increase feelings of lethargy, thinking problems and feelings of Depression.
- Motivates person to do more
- Improves ability to think clearly [100]
- Effective way to reduce stress.
- Increases muscular strength, endurance and flexibility.
- Relieves muscle tension caused by stress

[96] Beyond blue
[97] <http://www.psychology matters.org/exercise.html> - (viewed 20/9/08)
[98] Phillips, p158
[99] Blackdog
[100] WHO p.162

- Provides relief from emotions i.e. anxiety and depression. [101]

In examining this list there can be seen to be great mental and physical benefits in increasing activity for woman with Depression.

Limitations with physical activity

- Despite benefits a woman with Depression continues to have negative and pessimistic thinking. This affects motivation to increase activity levels. The woman will need to learn to plan and set goals for doing activities to increase her motivation. [102]
- Woman may have disability or health problem that affects level of activity.

As the woman becomes motivated to increase activity she can develop a regular exercise programme, using some enjoyable activities. Some woman may not naturally enjoy exercising. They will need to see benefits of exercise.

Exercise has many benefits for woman with Depression. It may reduce stress levels, affect thinking and emotions. However, it will need to be used in combination with other treatments.

(f) Relaxation

The women with Depression may be experiencing stress and anxiety in her life.

Stress effects person's mood and thought processes. It affects chemical balance of serotonin in brain and normal breathing patterns. Poor breathing reduces flow of oxygen and carbon dioxide to and from body, making it harder for person to cope. Results are anxiety, panic attacks, depression, muscle tension, headaches and fatigue. [103] Various techniques may assist a woman to reduce anxiety and depression.

Stress management techniques:

Some techniques that may assist with relaxation in order to mange depression are;

- Acupuncture - Few studies support the view that it may alleviate Depression. [104]
- Yoga - uses exercises with breathing. Reducing stress and anxiety, leading to depression. Many studies show benefits in managing depression. [105]
- Mediation – person focuses on object and word. Seen to be successful in management of Depression, obsessive thinking and anxiety. [106]
- Guided imagery – Effective in managing stress-related and physical illnesses. It assists with general and situational anxiety [107]
- Massage therapy - Produces chemicals changes in brain; resulting in relaxation, calm and well-being. It is responsible for reducing levels of stress hormones.

[101] Davies, 265-6
[102] WHO, p163
[103] Davis p.21
[104] Blackdog
[105] ibid
[106] Davis, p37
[107] ibid

Thought to benefit person with Depression - further study needed for evidence. [108]

- Breathing techniques
  - deep breathing - reduce body's stress response and assists calming mind. [109]

  - Reduce generalised anxiety disorders, panic attacks, agoraphobia, irritability, muscle tension, headaches, and fatigue.
  - Breathing awareness and good breathing improves psychological and physical well-being.[110]
- Progressive relaxation
  - assists awareness of tense and relaxed body parts
  - allows relaxing parts of their body and quickly relax in stressful situations.
  - reduce tension and assists with anxiety
  - Most effective - depression, anxiety and other stress related effects. [111]

Christian view of meditation:

Eastern mediation may be useful for some people with different beliefs. However, it's not suitable for Christian woman. She needs to focus on God's word, pure things, resulting in right living for God and gain God's peace. (Phillipians 4:8-9) The woman needs to mediate regularly on God's word, allowing quiet, relaxed mind, positive and non-provoking stress related thoughts. It may assist reduction of stress, anxiety and stress-related effects. However, severely depressed or agitated woman may become more depressed due to autonomic nervous system involvement. [112]

Stress management techniques may assist woman with Depression in reducing anxiety. Christian mediation may have benefits for spiritual, mental and physical well-being. However, relaxation will need to be used with other treatments.

(g) Journaling

Journaling may assist women with Depression to express thoughts and emotions.

Daily or weekly journaling can be most useful in the treatment of anger, anxiety and many other conditions. It helps person to take daily mood record, self-talk record, dispute thinking and take positive steps to improve problems. [113]

There are some benefits of personal, reflective journaling. Studies show person whom journals regularly may have 30 % fewer visits to GP. It is seen that putting deepest thoughts and feelings down on paper have healing value; emotionally, physically and spiritually. It can relieve person's pain, reduce stress causing headaches, high blood pressure and Depression.[114]

[108] Blackdog, 2008
[109] Hart p185
[110] Davis, p.21-22
[111] Ibid p 31
[112] Hart, p. 187-188
[113] Litchfield, Volume 3, p125
[114] Hart, p203

Journaling has some benefits for woman with Depression. It may assist them to express thoughts and feelings and reduce stress causing Depression.

(h) Cognitive behaviour therapy

The woman with Major depression needs to learn to deal with irrational thinking patterns, changing her view of herself and the world.

What is cognitive behaviour therapy?
Cognitive behaviour therapy is an active, directive, structured, educational, and problem solving approach. It aims to change cognitive processes and behaviour. It mostly uses cognitive restructuring, however, uses other techniques i.e. problem-solving, coping strategies, assertiveness. Cognitive restructuring involves understanding the development and nature of thought processes and behaviour. When these are understood there is a changing of irrational thoughts and maladaptive behaviour. [115]

Benefits of Cognitive behaviour therapy

- Allows person to identify irrational and negative thinking, affecting mood. Teaches person to change thinking. It allows them to adjust their perspective of world.
- Allows person to break free of negative thinking patterns. [116]
- Proven to be effective in person with mild and moderate Depression and anxiety disorders. [117]
- Suits non-bipolar and non-psychotic depressed persons. [118]

Limitations of behaviour cognitive therapy

- Not suitable for suicidal or severely depressed person. They may need hospitalization and/or other therapy. When stable - treatments may be used with cognitive therapy.
- Unresolved issues - Severe marital problems may require family/marital therapy. Cognitive therapy may have benefits after difficulties are resolved. [119]
- Needs to be combined with antidepressants treatment for those with moderate to severe Depression. Less effective in person with cognition dysfunction. [120] Cognitive behaviour therapy may assist woman with mild to moderate non-psychotic type Depression. However, the person with severe or psychotic Depression may not benefit. Cognitive therapy may need to be used alongside other therapies.

Christian view of cognitive behaviour therapy:

[115] Litchfield, p98
[116] Blackdog, 2008
[117] Davies, J, p 83
[118] Beckham p331-2
[119] Beckham p331-2
[120] Davies, p120

In Romans 12:1-11 secular concept of cognitive restructuring emerges. The idea of renewing person's mind and changing person core beliefs is identified. The transformation of a person is spiritual. The person learns to change core beliefs and align them with God's thoughts, through God's word and the Holy Spirit's work. Therefore cognitive restructuring goes beyond renewing the mind. It involves assisting a person to restructure thinking, based on true reality in God. [121] Ephesians 4:22-24 refers to the idea of restructuring a person's mind. It identifies with the idea of putting off old thinking and beliefs. New thinking and beliefs are based on God's word.

For Christian woman, real change will involve more than altering sinful behaviour patterns. It means moving into the darkened mind and learning what it means for Spirit of God to renew our thinking. Real change will come from change within the inner man. [122]

Cognitive behaviour therapy may assist woman with Depression to identify and change thinking. However, real change of a person's mind with Depression comes from focusing on God's word and being transformed by his Holy Spirit. It involves more than identifying and changing irrational thought patterns. Sinful and negative thoughts will need to be identified and confessed to God. The person will need to learn to live for God not conform to this world's thinking and beliefs.

(i) Assertiveness training

The women with Depression will need to learn to express feelings to others.

What is assertiveness training?

Assertion is the ability to stand up for rights. It involves expressing feeling towards others without damaging them. [123] Assertiveness training allows person to develop assertiveness.

Davies refers to things that are part of assertiveness training;

- Evaluating current patterns of communication
- Distinguishing between aggressive, passive and assertive styles of communication.
- Teaching person to express feelings and opinions
- Setting limits and initiating change
- Learning to listen assertively
- Avoiding manipulation. [124]

[121] Litchfield, Volume 3 p98
[122] Crabb in Litchfield Volume 3 p.129-130
[123] Tanner S, and Ball, J, 1991, Beating the blues, A Self-help approach to overcoming Depression, Southwood Press p132
[124] Davis, p 197

Benefits of Assertiveness training

- Learn to express feelings without them building up in intensity and become overwhelmed.
- Allows person to feel more in control of situations and reduces stress. . Research shows assertive behaviour can assist person to prevent further experiences of Depression. [125]
- Effective in dealing with depression, anger, resentment and interpersonal anxiety. Person becomes more assertive, more relaxed and take better care of self. [126]
- Develop healthy boundaries for self and with others

Limitations of assertiveness

- It may not be an easy skill to learn, especially for woman with moderate to severe Depression. She may not have cognitive ability to change thinking and beliefs about self.
- It takes hard work to learn and practice this skill.

Assertiveness training may assist a woman to learn to express herself. She can learn to become more outward in communication rather than inward. It may reduce stress and anxiety, and manage Depression.

Christian view of Assertiveness

Becoming assertive seems not that different to how God desires the woman to relate to others. God desires women to build healthy relationships with others. As part of the body of Christ the Christian woman needs to learn to encourage, build up and support others. The Christian needs to learn to speak the truth in love. (Ephesians 4:15) The woman needs to be honest about thoughts and feelings with others, without harming them. The Christian woman is to be transformed to become more like Christ. This involves being kind and compassionate. She needs to be genuine and learn to speak truthfully to others. This will not allow emotions to build up inside. (Ephesians 4:23-32)

(j) Building self-esteem

The woman with Major Depression will most likely have a low self-esteem, based on her negative thinking, beliefs and feelings about herself.

There are false beliefs that make a person vulnerable to Depression.
These include;

[125] Tanner, p135
[126] Davis, p 202

- I must prove that I am worthwhile based on achievements
- I must do things perfectly or not all
- I must have everyone's approval all the time
- I need to be loved by someone to be worthwhile
- The world must be fair and just.

[127]

The woman with Depression will need to break through false beliefs about self, others and the world around them. This may help her to improve self-esteem.

According to Tanner improving self-esteem may be achieved with cognitive therapy, changing thinking about self. She discusses four steps for improving self-esteem;

- Stop trying to prove yourself – this involves accepting and loving self for what you are, being self and enjoying experiences
- Challenge negative thinking – assists to detect negative thinking, understand values and beliefs affecting Depression.
- Be definite about your positive points – have positive statements about self and life.
- Respect yourself - treating self like a friend.

[128]

The building of self-esteem may assist woman in changing thinking about self and others.

Christian view:

The building of self-esteem has its focus on self. Self is changeable. The woman needs to learn to focus on God and his opinion of her. This involves changing her false beliefs of needing to be accepted, approved and loved by others. God desires that the woman finds true identity and acceptance in him. The woman needs to learn to see herself as God sees her, truly loved and accepted by him despite being sinfulness. (Romans 5:8) It will be in knowing who she is in Christ that will enable her to overcome false beliefs about self. The woman with Depression will need to learn to accept herself as being created in God's image and uniquely for his purpose. (Genesis 1:27)

(k) Family therapy

A woman with Major Depression may have some family and/or marital problems which need to be addressed. Depression may also have a huge impact on the functioning of the family. There may need to be a family approach to therapy.

Keinter examines bio-psychosocial approach to Major Depression, taking into consideration social environment. Distress and problematic family functioning are seen in more than half of persons with Major Depression. Similar dysfunctions existed for chronically and acutely depressed person. The changes in person environment, lack of support and inability to confide in spouse may increase risk of

[127] Tanner p119
[128] ibid p. 128-131

Depression. Poor family functioning is seen to affect recovery and/or relapse of Depression. Relapse of Depression has been related to marital distress. [129]

Biomedical approach does not take into consideration the influence that the marital and family situation may have on development and relapse of Depression. That means there is a need to consider the bio-psychosocial approach that includes family therapy.

What is family therapy?

Family therapy focuses on the relational components of the individual problems. The person is seen as being part of a social system, beginning with the family and then significant others. [130]

Benefits of family therapy:

Different approaches of family therapy that may assist person and families with Depression. These include strategic marital therapy, behavioural marital therapy (BMT), cognitive marital therapy and problem-centred systems therapy of family.
Studies attended on depressed wives with marital distress have been undertaken. These tested effectiveness of BMT family therapy. The results included;

- Behavioural marital therapy (BMT) - comparable to individual therapy in improving depressive symptoms. Better than individual therapy in improving marital functioning
- Family therapy - particularly helpful with family distress as component of Depression.
- BMT and cognitive therapy (CT) were equally effectiveness in reduction of depressive symptoms. BMT was much better at reducing marital distress. [131]

Other benefits of family therapy include;

- Assists understanding, improve family member's interaction and resolve family conflicts.
- Help to identify family strengths and weaknesses (Mayoclinic – Healing family conflicts) [132]
- Assists family members to develop an understanding of Depression and find new ways of supporting the person. [133]

Family therapy can have many benefits for the woman with Depression. It can help the woman with depression to identify areas that may contribute to Depression, work through them and gain the support of other family members. This will take commitment from family members. One important component is missing in secular models. That is the spiritual aspect.

Christian approach to family therapy:

[129] Keitner,G, 2005, 'Family therapy in the treatment of Depression' *Psychiatric times*, October, 2005, <http://psychiatrictimes.com (viewed 20/9/08)
[130] Litchfield - Volume 5 p. 63
[131] Keinter in Psychiatric times
[132] Mayoclinic
[133] Beyond blue

An integrated approach to family therapy, involves psychodynamic, experiential, cognitive-behavioural, strategic and systemic models within Christian context. (Litchfield - Volume 5 – Jones and Butman p.347-76) [134]

Litchfield's family therapy model is a one such family therapy model. Its main difference to secular family models lies in the strong emphasises on God changing people and families.[135] (See Appendix for model)

It is important to gain a bio-psychosocial approach to managing the woman with Major Depression. There are benefits in secular family therapy. They take into consideration the influence that family and/or social environment have on woman. However, they lack the spiritual component. Real change in a woman with Depression and her family will ultimately come from God transforming them from the inside out.

Conclusion

In overview it is important to recognise that the incidence of Major Depression in women is higher than in men. However, it is difficult to determine the reason for this. It may be related to women seeking assistance for Depression. On the other hand it may be related to women biological, mental and emotional uniqueness. In exploring factors that may influence the onset of Depression it was seen that there is no definite cause for Major Depression. There are many different theories that have been proposed about Major Depression. These include biochemical, biological, genetic, environmental, psychosocial, mental/cognitive and relational theories. In exploring these risk factors there was seen to be biological, mental and emotional factors unique to women that need to be taken into consideration.

It is not enough to have a biomedical approach to Major Depression in women. There needs to be a comprehensive approach to understanding women with Major Depression. The spiritual aspect of woman needs also to be taken into consideration. Whilst Depression may be related to personal sin it is more likely related to a combination of factors, including being in broken world. In gaining understanding of factors affecting onset of Major Depression in women will allow for holistic approach to management of women with Major Depression.

In examining management of women with Major Depression different therapies were explored. These therapies involve acute, immediate and long-term management of women. In exploring therapies there has been examination of benefits and limitations. Various researchers and health professionals held different views about these therapies. There was seen to be benefits for each therapy. However, these were not enough to sufficiently manage Major Depression alone. In gaining overview of therapies it can be seen that there needs to be an integrated approach to managing women with Depression. There needs to consideration of the biological, psychological, emotional, mental/cognitive, social and spiritual aspects of the woman in managing Major Depression.

[134] Jones and Butman, 1991, Modern Psychotherapies: A comprehensive Christian appraisal, Intervarsity Press, Downers Grove, in Litchfield, 1991 p.347-76
[135] Litchfield Volume 5, p119

Individual women are different in their physical, social, emotional, psychological and spiritual well-being. Given the complexities of different women there needs to be an individualised approach to managing the women with Major Depression. Some therapies may work for some women. However, some may not work for others. It will be necessary for women with Major Depression to trial different therapies in combinations with other therapies to gain good outcomes.

For the therapist working with the women with Major Depression there will need to be a comprehensive assessment of the individual's situation. This will allow them to gain the integrated approach needed to manage a women with Major Depression. With increased understanding of the need to use an integrated approach improved outcomes will be achieved.

Bibliography

Beckham, E and Leber, W, 1995, Handbook of Depression, 2nd edition, New York, The
Guildford Press.

Crabb, L, 1987, Understanding people: Deep longings for relationship, Oakleigh, Intersac

DSM –IV-TR, 2000, American Psychiatric Association, Arlington

Davis, M, Eshelman, E and McKay, M, 2000, The relaxation and stress reduction workbook, fifth edition, Oakland, New Harbinger publications

Davies J, 2003, A Manual of[i] mental health care in general practice, Commonwealth Department of Health and Ageing, Canberra

Davidson and Neale, 1990, Abnormal Psychology, John Wiley and Sons, New York

Hart, A and Hart Weber, C, 2007, A Woman's guide to overcoming Depression, Grand rapids, Spire

Jones and Butman, 1991, Modern Psychotherapies: A comprehensive Christian appraisal, Intervarsity Press, Downers Grove

Litchfield, B and N, 2006, Christian counselling and family therapy, Volume 3. Canberra, Litchfield Family Services

Litchfield, B and N, 2006, Christian counselling and family therapy, Volume 4. Canberra, Litchfield Family Services

Litchfield, B and N, 2006, Christian counselling and family therapy, Volume 5. Canberra, Litchfield Family Services

Keitner,G, 2005, 'Family therapy in the treatment of Depression' *Psychiatric times,* October, 2005, <http://psychiatrictimes.com - viewed 20/9/08

NIV Bible, 2001, Grand rapids, Zondervan

Phillips, Bob, 2007, Overcoming Anxiety and Depression: Practical tools to help you deal with negative emotions, Eugene, Harvest House Publishers

Rao, S, 2008, Understanding nutrition, depression and mental illness, <http://www.indianjpsychiatry.org/article> - viewed 20/9/08

Tanner S, and Ball, J, 1991, Beating the blues, A Self-help approach to overcoming Depression, Southwood Press

Toronto, G and Anagnostakos, 1990, Principles of anatomy and physiology, New York, Harper and Row.

World health Organisation, 2004, Management of Mental health disorders, Sydney, World health organisation

<htp//www.beyond blue.org.au/depression> - viewed 10/07/08

<http//www.black dog institute.org.au/depression> – viewed 1/3/08

<http://www.mayoclinic.com/print/major depression> - viewed 20/9/08

<http://www.psychology matters.org/exercise.html> - viewed 20/9/08

Reference

Crabb, L, 2001, Shattered Dreams: God's unexpected pathway to joy, Colorado, Water brook

Kendler K, Gardner, C and Prescott, C, 2002, Toward a comprehensive developmental model for Major Depression in women' *The American journal of Psychiatry*, July, 2002.

Susan, 2006, Depression and women: An integrative treatment approach, Springer

<http://www.betterhealth.vic. gov.au/Depression and exercise - viewed 1/3/08

<htp://www.depressionnet.com.au./depression> - viewed 20/9/08

<http://www.helpguide.org/mental/depression_women.htm> - viewed – 19/9/08

< http://www.mental help.net/major depression> - viewed 19/9/08

<http://www.psychologyinfo.com/depression/women.htm> - viewed 1/03/08

<http://ajp.psychiatryonline.org/depression> - viewed 19/9/08

Appendix

Assessment tools used from diagnosis Depression

Assessment tool from Diagnostic and Statistical manual (DSMIVTR):
This can be used by psychiatrist, doctors, psychologist, social workers, nurses and counsellors to determine whether a person has Depression.
During last two weeks have you had?
(1) Depressed mood
(2) Loss of interest or pleasure
If you answer Yes to either of these questions Complete the following.
(1) Depressed mood most of the day
(2) Less interest of pleasure in all activities
(3) Weight loss or gain in all activities
(4) Sleeping difficulties
(5) Slowed or fasted movements
(6) Tiredness or loss of energy
(7) Feeling worthless
(8) Difficulty concentrating
(9) Thoughts of death
[136]

Kessier Psychological distress scale (K10)
This assessment tool can be used by various health professionals i.e. GP, Mental health professionals, counsellors and community Nurses. It is a user-friendly assessment tool. It involves asking 10 questions and response of none or little of time to determine mental status of person.
In the past 4 weeks about how often did you feel;
(1) tired out for no good reason?
(2) Nervous?
(3) So nervous that nothing could calm you down?

[136] Beyond Blue

(4) Hopeless?
(5) Restless?
(6) So restless you could not sit still?
(7) Depressed?
(8) Everything was an effort?
(9) So sad that nothing could cheer you up?
(10) Worthless? [137]

SPHERE QUESTIONAIRE:

This is a more comprehensive assessment tool attended by GP to identify with the mental status of presenting person. It was developed under the mental health initiative of Australia. It involves a variety of questions in areas of behaviour, thoughts, feelings and physical status.

For more than two weeks have you:
(1) felt sad, down or miserable of the time?
(2) Lost interest or pleasure in most of usual activities?
If you answer Yes to either these questions complete the following symptom list.
Behaviours
(1) Stopped going out
(2) Not getting things done at work
(3) Withdrawn from close family and friends
(4) Relying on alcohol and sedatives
(5) Stopped doing things you enjoy
(6) Unable to concentrate
Thoughts
"I'm a failure"
(8) "It's my fault"
(9) "Nothing good ever happens to me"
(10) "I'm worthless"
(11) "life is not worth living"
Feelings
(12) Overwhelmed
(13) Unhappy, depressed
(14) Irritable
(15) Frustrated
(16) No confidence
(17) Guilty
(18) Indecisive
(19) Disappointed
(20) Miserable
(21) Sad

[137] Ibid

Physical
(22) Tired all the time
(23) Sick and run down
(24) Headaches and muscle pains
(25) Churning gut
(26) Can't sleep
(27) Poor appetite/eight loss [138]
In the case of a person requiring Psychiatrist assessment DASS and/or BDI will be used.
DAAS is a 42-item scale. It has a three factor score which distinguishes whether person has depression, anxiety and/or stress-related problem. They may have a combination of these. DASS- Depression characterised by depressed mood, low-self-esteem and sense of hopelessness. DAAS Depression factor – 0-9 normal, 10-12 mild, 13-19 Moderate, 20-26 severe depression and 27-42 extremely severe depression. All diagnostic decisions need to be backed up by expert clinical interview. [139] Sample copy from Blackdog Institute. [140]

SAMPLE COPY (DAAS)

[138] Beyond Blue
[139] WHO p 149-50
[140] Blackdog

Beck Depression (BDI) - This assessment tool is widely used to measure severity of Depression, not used to diagnose Depression. This is a 21-item scale with symptoms and attitudes. Items are rated on 0-3 scale based on intensity. Originally used as interviewer-administered, however, now used as a self-administered scale.[141]

SAMPLE COPY (BDI)

[141] WHO p 150

THERAPHY:

Crisis management

Questions for assessing suicidal ideation

1. Have you been feeling depressed foe several days at a time?
2. When you feel this way, have you ever had thoughts of killing self?
3. When did these thoughts occur?
4. What did you think you might do to yourself?
5. Did you act on these thoughts in any way?
6. How often do these thoughts occur?
7. When was the last time you had these thoughts?
8. Have your thoughts ever included harming someone else as well as yourself?
9. Recently, what specifically have you thought about doing to yourself?
10. Have you taken any steps towards doing this?
11. Have you thought about when and where you would do this?
12. Have you made any plans for your possessions or left any instructions for people for after your death, such as a note or a will?
13. Have you thought about the effect your death would have upon your family or friends?
14. What has stopped you from acting on thoughts so far?
15. What are your thoughts about staying alive?
16. What help could make it easier for you to cope with your problems at the moment?
17. How does talking about all this make you feel? [142]

WHO refer to assessment of person for hospitalisation

[142] WHO p22-230

Risk of intentional harm to self or others

- Has individual expressed intention to cause harm to self or others?
  If threats to harm another person clinician has a duty to warn person.
- Is intention to cause harm related to psychotic thinking? i.e. hallucinations
- Does person have plan of action?
- Does person have access to means? i.e. weapons, drugs etc
- Has person attempted suicide or harmed others in past?
- Does person live alone or unsupervised?
- Is there evidence of impulsive behaviour? Now or in past?
- Does person use amphetamines, alcohol and/or other substances?
- Other considerations
- Person living alone and too ill for adequate self-care?
- 24-hour assistance available? i.e. family, friends, crisis team, GP
- Does the person live too far from outpatient treatment?
- Does self-harm arise based on personality disorder? i.e. borderline personality. Hospitalisation may be counter therapeutic.
- Hospitalisation may be necessary if psychiatrist diagnosis is unclear or person requires ECT.[143]

Medical:

Medical and counselling models: [144]

[143] WHO p.154
[144] Phillips, p79

Types, benefits and limitations of antidepressants:

Selective serotonin reuptake inhibitors (SSRI's)
Includes; Sertraline (Zoloft)
Citalopram (Cipramil, Ciazil, Talohexal)
Paroxetine (Aropax, Erocap, Lovan, Zactin, Auscap)
Fluvoxamine (Luvox, Faverin)
Side effects include; anxiety, headache, diarrhoea or constipation, sexual dysfunction, sweating and increased risk of GI bleeding.

Serotonin and noradrenaline reuptake inhibitors (SNRI's)
Venlafaxine (Efexor, Efexor-XR)
Noradrenaline reuptake inhibitors (NARI's)
Reboxetine (Edronax)
Side effects: difficulty with sleeping, urinating and sexual problems.

Tricyclic antidepressants (TCA's)
Notriptyline (Allergon)
Clomipramine (Anafranil)
Dothiepin (Prothiaden, Dothep)
Imipramine (Tofranil)
Amitraptyline (Tryptanol, Endep)
Side effects; Side effects: more than newer drugs, including high blood pressure requiring monitoring.
Sedating effects, blurred vision, dry mouth, constipation, delirium, weight gain, postural hypotension. Can be lethal in overdose.

Monoamine Oxidase Inhibitors (MAOIs).
Reversible inhibitors of monoamine oxidase –A (RIMAS)
Moclobemide (Aurorix, Arima)
Side effects; increased appetite and weight gain.

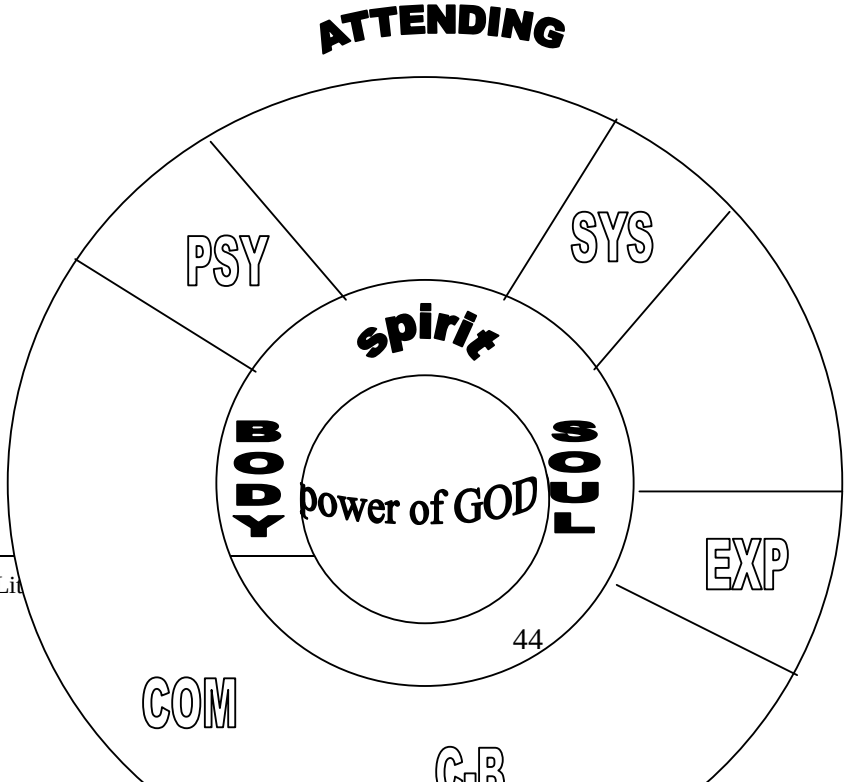
Noradrenaline-serotonin specific antidepressants (NaSSA's)
Relatively new drug. Particularly helpful with anxiety and difficulty
Low on sexual side effects [145]

NUTRITION:
Food Pyramid

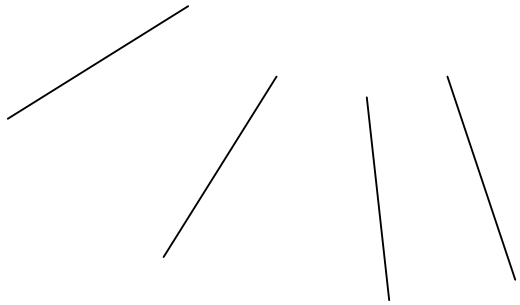
[145] Beyond blue

Family therapy: [146]

DIAGRAM OF LITCHFIELD FAMILY THERAPY MODEL:
The Model can be illustrated as a wheel. It is based around the power of God driving the wheel. Person is made up of spirit, soul and body. Five therapies make up the Model. These are applied through use of core skills. Eight core skills: attending, respect, empathy, genuineness, concreteness, challenging, immediacy and self-disclosure.



[146] Lit



Family therapy steps
Identified patient (and family)
The genogram
Understanding the family of origin
Understanding the current family
Learning to talk, feel and trust
Multigenerational transmission
Differentiation of self

- Cognitive restructuring
- Dealing with resentment
- Dealing with guilt
- Making restitution
- Identity and self-acceptance
- Assertiveness training
- Letting go of control

Communication
Building relationships
The Christian community
Other issues

Clinical application of Family Therapy Model:
Step-by-step procedure:
Session 1-3: IP and family members – Initial assessment – involving active listening to each family member. Submit tentative diagnosis and therapy plan.
Session 4: IP – Complete genogram
Session 5-6: IP – Trauma list
Session 7: IP – Resentment/forgiveness list – may take more than one session

Session 8 +: Other family members – involves active listening – may take a few sessions and may come earlier in sessions
Session 9: IP – Guilt list
Session 10: IP – Identity/self-acceptance, Assertiveness training
Session 11: IP – Other issues
Session 12+: Family - Parenting, marital, sexual, communication, addiction and other issues – could be several sessions and may come earlier
Session 13+: IP and family – every 6 weeks for accountability and maintenance for 12 months

ii