

case study:

DEPRESSION

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I. PRESENTATION OF THE PATIENT

We are presented with an elderly woman with a history of long term Multiple Sclerosis, married 40 years, presenting with severe depression and suicidal gestures. The patient agreed to therapy on the advice of 1 of her 3 sons for the complaint of “difficulty relating to her husband.” The patient raised her 3 now adult sons mostly by herself due to her husband’s 20 year career in the Merchant Marines.

The patient had periods of severe anger towards her husband apparently because of his alleged lack of emotional support and love. When she engaged in self harm to gain his attention, that having failed, the patient apparently progressed to increasingly severe forms of suicidal gesturing. The husband’s response was, not to offer the emotional attention and love the patient craved, but rather to arrange for commitment of his wife to a psychiatric facility.

The patient and her husband had recently moved 60 miles from their long time home where she had a school support job that yielded great satisfaction in interacting with children and teachers. The commute being too long, the patient had to give up that job. She was socially isolated and withdrawn in her new home, having no initial social contacts or activities. The patient felt the only time that her husband would give her the attention and love she craved from him was when the couple became romantically intimate. The perspectives offered by the patient and her husband on the state of their marital affairs differ widely.

II. ASSESSMENT OF THE PATIENT

Firstly, a hospital emergency room evaluation is needed by emergency physicians and nurses to rule out any life threatening organic causes of the patient’s aberrant behavior - such as hypoglycemia, hypoxia, thyroid, liver or kidney dysfunction. After medical clearance, this patient requires immediate evaluation by emergency psychiatric crisis intervention staff to determine the true acute level of suicide risk. The patient’s physician should be consulted without delay. A course of admission to a hospital psychiatric unit for stabilization of the patient’s depression and suicidality with

medication and initial therapy is certainly reasonable. “Commitment” of the patient involuntarily to a secure psychiatric facility is much less likely if this course of action is followed and should only be considered as a last resort.

Secondly is the patient’s Multiple Sclerosis. MS is associated with loss of muscle coordination in multiple neurological systems - including sexual function. Not only will this patient’s self image and feelings of self worth be eroded by the symptoms of her ongoing MS, but also her ability to obtain whatever limited emotional attention and love she once was able to obtain from her husband via sexual relations. Further, MS is known to be associated with abnormally high rates of depression. Further, some medications given for MS themselves are known to reduce brain serotonin levels and cause depression.

Thirdly is the patient’s anger. This patient - in desperate attempts to obtain attention and emotional support from her husband, first directs her anger towards him when he fails to engage her, then against herself in escalating self destructive behaviors in an attempt to gain his show of affection. Given the timid, weak and dependant personality of the patient, it is little wonder she resorts to such external and internal anger due to her husband’s lack of affection towards her.

Fourthly is the patient’s use of valium. Valium is a well proven anxiolytic for short term control of acute anxiety states. It may also provide some relief of muscle spasms in this case where MS is present, thus relieving some discomfort. However, valium is certainly not appropriate for treating serious depression, nor is it appropriate as an analgesic. This patient requires immediate full medical evaluation to determine possible organic causes of her pain and appropriate non-narcotic and possibly limited narcotic analgesic medications. This patient requires also immediate evaluation by a psychiatrist to evaluate her depression, suicidality potential and a regimen of antidepressant medications.

III. THERAPY FOR THE PATIENT

It must be asked if the husband is himself acting in some way as an emotional abuser of his wife. The husband apparently is: minimizing the patient's MS condition and its effects; making emotional attention and affection dependant on sexual relations; making major decisions for the couple irrespective of his wife's feelings; denying any responsibility for the couple's marital distress; lobbying family and health care staff to have his wife "committed" - presumably involuntarily - to a secure psychiatric facility.

In view of the evaluation of the husband as not likely to change, the patient should be reminded that it is GOD Who is sovereign over her life and not her husband. A closer and deeper relation with CHRIST offers to fill the apparent void in this patient's heart. "GOD is our refuge and strength, a very present help in trouble." [PSALMS 46:1]. JESUS said, "I will not leave you comfortless; I will come to you. Peace I leave with you, My peace I give unto you: not as the world giveth, give I unto you. Let not your heart be troubled, neither let it be afraid." [JOHN 14:18,27].

IV. PLAN OF CARE

Redecision therapy may offer some hope in this case: a) Injunctions are those implied statements made by significant others. Is the patient's husband saying to her, "You are only good for sex, and you can't even do that any more because of your MS." Is the patient answering, "I'm worth so little I might as well kill myself. I can't even give my husband sex any more because of my MS. I am worthless." b) Scripts are past decisions that the patient made in response to those injunctions. In this case, the patient's fruitless attempts to obtain her husband's attention via her anger at him and her suicidal gestures. c) Impasses are scripts that are being lived out despite the fact that the script corresponds to past relationships and not the present.

The patient had felt alone and abandoned in the first 20 years of their marriage when her husband was in the Merchant Marines. It is possible she is reinforcing those past resentments against her husband for being absent into her present relations with him. d) Redecisions involve therapeutic contracts that are appropriate to counter past

ineffective and unrewarding decisions. The patient's Christian Faith offers a surer source of affection and love of An Infallible Nature in JESUS CHRIST. The patient may contract with herself and GOD to seek His Affection when her husband is not forthcoming with his imperfect earthly affection. "Beloved, let us love one another: for love is of GOD; and every one that loveth is born of GOD, and knoweth GOD. For GOD is love." [1JOHN 4:7-8a].

V. BIBLICAL FOUNDATIONS FOR INTERVENTION

Christian therapy intervention for this depressed patient: a) Sources of real and misplaced guilt should be identified. This patient needs to see she is not responsible for having MS and its possible effects on her ability to obtain affection of her husband via sexual relations. "But He that judgeth me is The Lord." [1 CORINTHIANS 4:4b]. "There is therefore now no condemnation to them which are in CHRIST JESUS." [ROMANS 8:1a]. b) Understanding the sovereignty of GOD must be established. Again, the patient needs to see that GOD is sovereign over her life - not her husband. "But GOD is faithful, Who will not suffer you to be tempted above that ye are able; but will with the temptation also make a way to escape, that ye may be able to bear it." [1 CORINTHIANS 10:13b].

Further, c) Things elevated to the level of need creating disappointments. Has the patient elevated her husband to the only source of affection in her life unrealistically, seeing he is only human? Has the patient elevated good health - which she is loosing due to her MS - as an absolute requirement for fulfillment? "Let no man say when he is tempted, I am tempted by GOD: for GOD cannot be tempted with evil, neither tempted He any man: But every man is tempted when he is drawn away of his own lusts, and enticed." [JAMES 1:13-14].

Further Christian therapy intervention for this patient: d) Faith is the cure when depression is equated to an emotional means to recoup perceived losses. This patient needs to focus of faith in GOD, which is the only way she will be able to let go of her angry and destructive emotions. "Now faith is the substance of things hoped for, the

evidence of things not seen.” [HEBREWS 11:1]. e) Prayer is how we approach The Throne of GOD to worship and to beseech. The patient will be able to let go of her depressive emotions in direct proportion to her reaching out to our Lord JESUS CHRIST in prayer. “Blessed is the man unto whom The LORD imputeth not iniquity. I will confess my transgressions unto The LORD; and Thou forgavest the iniquity of my sin. For thus shall every one that is godly pray unto Thee in a time when Thou mayest be found.” [PSALMS 32:2a,5b,6a].

“But the righteousness is of faith speaketh on this wise. The Word is nigh thee, even in thy mouth, and in thy heart: that is, The Word of Faith (CHRIST), which we preach.” [ROMANS 10:6a,8]. f) Patience holds onto promise more than disappointment. This patient needs to see that deliverance from her physical, emotional and spiritual burdens require her to wait upon The LORD for His will and not hers. “For we are saved by hope. Even we ourselves groan within ourselves, waiting for The Adoption, to wit, the redemption of our body. But if we hope for that we see not, then do we with patience wait for it.” [ROMANS 8:24a,23b,25].

VI. FINAL OBSERVATIONS

To conclude, the first priority in any case where there is suicidal gesture is to determine the suicide risk of the patient. This should be done in a hospital emergency room where medical clearance for the severe depression can also be done. All other matters considered will do no good if the patient is not protected from herself and commits suicide! Appropriate medication and therapy for the patient for depression must be immediately addressed. Both the patient and her spouse require ongoing individual therapy. Marital therapy should also be initiated. Christian clergy resources should be integrated into individual and marital therapy.

The patient should be encouraged to develop her identity of self independent of her spouse, while caution must be taken not to advise the patient to give up on her marriage. Adequate aggressive treatment of the patient’s MS may help lessen severity and duration of symptoms, improve mood and facilitate better sexual performance.

Continued support networking and group meetings for people with MS should be encouraged for both the patient and her husband together.

The patient and her husband should be dealt with in GOD's love, which may in turn flower within them individually and as a married couple. "Love suffered long, and is kind: love envieth not: love vaunted not itself, is not puffed up. Doth not behave unseemly, seeketh not her own, is not easily provoked, thinketh no evil; Rejoiceth not in iniquity, but rejoiceth in the truth; Beareth all things, believeth all things, hopeth all things, endureth all things. [1 CORINTHIANS 13:4-7].