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DEPRESSION - a Sensory Based Review

by
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The word Depression is like the word Pain. Physicians and surgeons will seek the sensory based description of what the pain is. By securing the information, it allows them to speculate the what might be the probable basis of the pain.
This paper proposes that it is equally critical for Psychiatrists and Psychologist and Psychotherapists to do so with Depression in order for them to determine what they are really dealing with and what might be the ways to manage and treat the condition.

In Medicine when a patient presents with a symptom, there is an implicit understanding that if the symptom is NOT sensory based that the physician will secure such a description. Thus, just to say that one has a pain in the abdomen is not sufficient. In the elicitation of what is happening the physician wants to know:

1. the manner of onset of the pain, i.e. whether it was sudden or gradual
2. the locus of origin of the pain
3. the intensity of the pain, whether it was gradual in its intensification or whether following its onset it remained constant
4. whether there was any remission in the pain
5. the duration of its remission
6. what was the duration of remission
7. what was the manner of its re-exacerbation
8. a description of the pain, i.e. whether it was ***twisting***, ***burning***, ***tight knot***, ***distending discomfort***, ***nagging ache***, **like a weight** and so forth
9. did the pain remain localized or did it radiate
10. What was the manner of radiation of the pain
11. where did it radiate to.

To a surgeon or physician, these sensory based descriptions carry significance of different import. They allow the surgeon or physician to infer the differential possibilities in the pathological basis of the complaint. Thus, the above of complaints may suggest a volvulus, an ulcer, an intestinal

obstruction, excessive presence of gas and a cancer. This is possible because the search for the sensory based description for the pain is in effect a way of de-objectifying the "pain." The word "pain" is an objectification of a process. The process if "feeling pain."

Now, the term "Depression" is also an objectification of a process. This process is "**feeling depressed**."

What is clear is that with the clinical condition of DEPRESSION, patients have unique and different sensory based descriptions of their experience. We shall cite some examples. These examples are in response to the two question:

1. What do you mean by Depression or feeling depressed?
2. What for you is the experience of Depression or feeling depressed?

From our enquiry, this was a scan of answers that we received. For these cases that we are citing below, Depression was experienced as :

I. a **whole body tiredness**. However it was **associated with an internal unclear and unfocused thought pictures** of the domain of concern that she felt depressed about.

II. a **whole body tiredness**. However this was associated **with an internal auditory dialoguing** in which **now and then there would be associated a thought picture** of the domain of concern. This internal dialoging was so intense and at such speed and above all it was so compelling with respect to his attention that he managed only 3 hours sleep. There was also the experience of an **absence of energy**.

III. a **whole body tiredness** associated with a intense desire of **wanting to go to sleep** and with the **eyelids feeling constantly heavy**.

IV. a sense of **whole body tiredness** with an associated feeling of **wanting to shed tears of frustration**.

V. a **heavy weight in the praecordium**.

VI. a **stillness over the chest**. This stillness was compared to a feeling of loneliness.

VII. a heavy weight across both shoulder. However, to direct enquiry, there was NO sense tiredness any where in the body.

VIII. a sense of **emptiness in the praecordium**. No tiredness and no lack of energy was experienced anywhere in the body.

IX. a **very tight discomfort in the area of the private parts**.

X. a **whole body tiredness and an overwhelming desire to sleep with concomitant heaviness of the eyelids**.

XI. a **whole body tiredness** with **loss of visual acuity of internal imagery and external sight**[1].

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[1] **XI**: This last description was offered to us by a Neurologist from Montana, USA during the presentation of our paper, *Time and the Ontology of Depression*, at the 41st Scientific Meeting of the American Society of Clinical Hypnosis.

These sensory based descriptions are clearly metaphors for distinct internal physiologies. They have to be since it is only a given physiology can sustain whatever it is that the patient is complaining of. The question is what is the condition for these distinct, unique and different phyiologies.

There is much out of human intuitions to suggest that these distinct internal physiologies are by-products of unique internal sentient processings. Certainly in Case and B the feedback seemed to confirm this. Thus when we put it to A, "If we were able to stop the internal imaging, do you think it would help with your Depression?" She replied with no uncertainty, "Yes!" In our view, in case B, the internal dialoging was the form and manner of his thinking. It was something that in our view an activity that was taking up vast amounts of energy which left him with nothing for anything in his life. When we put it to him, "If we turn off this internal audio tape, would it remit your Depression?" He replied, "Of course!"

For those who come from the field of Clinical Hypnosis, is the knowledge that internal sentient processing can be conscious and it can be unconscious. In the latter it means that the processing is not in conscious awareness. In any event, whatever may be the initial conditions, any transformation of an initial state to another is not an event that **JUST HAPPENS**. If the conditions change the person has to determine how he is going to respond to these new conditions. This determination, regardless of whether it is conscious or not, presupposes that the individual will undertake the appropriate internal computations to meet the challenges of the new circumstances.

If this is the case, the we are say that all internal states can only be functions of the concomitant internal processing. The latter are the critical internal sentient steps that determine the form of semantic states that a person arrives at. In this instance, it is the internal semantic state of Depression.

In turn this semantic state is the basis for the unique form of external behaviour that is associated with the condition of Depression. Thus, the universal feature of Depression in the way it is externalize is the impaire ability to function. This impaired ability is not solely because the person suffers from a sense of whole body tiredness and loss of energy. In Case VIII the subject was a very action oriented dentist. It was a feature of his ontology that he consistently enjoyed a sense a warmth in his praecordium. It was from this ontology that he would determine the kind of actions and behaviours that he undertook in his life. When this warmth became absent and was replaced by a sense of emptiness, he