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FUNCTIONS of DEPRESSION

by

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IN THIS PAPER, THE MALE PRONOUN WILL APPLY TO EITHER GENDER. THE PLURAL PRONOUN WILL APPLY TO BOTH AUTHORS. THE NOMINAL PRONOUN WILL APPLY TO THE FIRST AUTHOR.

We dedicate this paper to
Professor Saroja Krishnaswarmy
a lady of finesse and a professional of distinction

Abstract

The word "depression" is like the word "pain." Physicians and surgeons will seek the sensory based description[1] of what the pain is. By securing the information, it allows them to speculate what might be the possible pathological processes for the pain. This paper proposes that it is equally critical for Psychiatrists, Psychologists and Psychotherapists to do so in a similar way with the word "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 stated in sensory based terms, the physician will secure such a description. Thus, just to say that one has a pain in the stomach 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 of the pain
5. the duration of its remission
6. what was the manner of its remission, sudden or gradual

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 complaints may suggest a volvulus, an ulcer, an intestinal obstruction, excessive presence of gas or 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 is "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 three questions:

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

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 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**[2].

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

VII. a **heavy weight across both shoulders**. However, to direct enquiry, there was NO sense of tiredness anywhere 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** with **loss of visual acuity of internal imagery and external sight**[3].

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

These distinct internal physiologies are by-products of unique internal sentient processing. Certainly in cases I and II, the feedback seemed to confirm this. Thus, when we asked these respective patients, "If we were able to stop the internal imaging, do you think it would help with your Depression?" they replied with no uncertainty, "Yes!" In our view, in case II, the internal dialoging was the form and manner of his thinking. It was something that was an activity that was taking up vast amounts of energy which left him with none 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!" When we put to case V, "If this heavy weight can be lifted off your chest, do you think that your Depression will go?" He replied, "Most surely."

Those who come from the fields of Psychotherapy and Hypnotherapy, know that internal sentient processing can be conscious and it can be unconscious. In Hypnotherapy often 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 conditions change, a 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, then we are saying that all internal states can only be functions of the concomitant internal processing. The Internal processing involves 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 externalized, is the impaired 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.

What are possible internal processes that may determine a condition of Depression?

Our research to this point has failed to find an overall pattern. We have been left to conclude that each case to which we name as Depression has its own unique internal process. This presentation does not examine what a clinician is to do to elicit the structure of the internal processing. To discuss and teach this would entail a three day workshop.

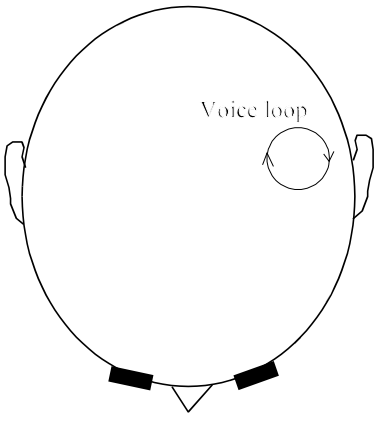
What we have decided to do is index three unique cases to index what is cited here.

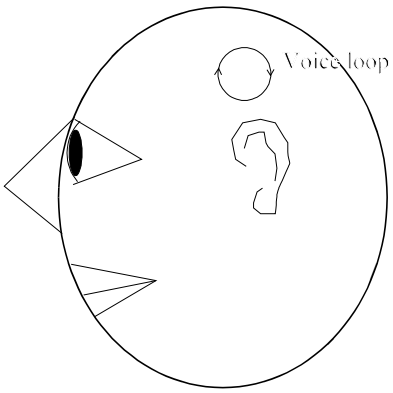
<u>The first case was a function of an internal auditory tape loop</u>:

The patient was a man who was in Chronic Depression. When finally Prozac came on the market with all its accompany hype, he thought the moment of his salvation had come. It was a matter of bitter disappointment that it did nothing for him. It was, therefore, a very sad and disappointed man who came to see us.

In the course of our work with him, we then discovered that he was the child of a very strict household. As they would say, both parents were of the old school and they came from the old country. Everything had to be done RIGHT. Wrong was not tolerated in this severe and unrelenting environment in which he was brought up. For every infraction he was severely chastised with the denunciation, "You are useless! You are worthless!"

We were soon able to confirm that this was now a internal auditory tape loop that he heard inside his head. He heard it at below conversational volume and it was his father's voice. He told us that he heard it in his head. Can you imagine living out every second of every minute and every minute of every hour and every hour of every day with your father telling you that you are useless and worthless. Anyone would become depressed. We diagram below what was going on:





What then was the treatment?

Two things had to be done. The first was obvious. It was to apply the manouevre of Auditory Pragmagraphics[4] to delete the tape loop. Once this was done, the Depression, so named, lifted from the man. However, it was also critical to ensure that this wound of his childhood was healed and that all negative emotions, such as anger and bitterness, especially towards his parents, would be ended. This was done by taking him through the Question of WHY Seminars[5] and applying the Gurudev Manouevres[6].

<u>The second was a function of a Modal Operator</u>:

The patient was a man who had suffered from Depression for some 22 years. Every medication for Depression had been tried on him with dismal results.

When I met him, I took his clinical history. I found out that he had one brother who had committed suicide. I asked him how he felt about his death. This question is known as the Satir meta question after Virginia Satir[7]. He replied, "Terrible!" I then asked him, "Terrible because **...** ?" He said, "Because I feel so responsible!" I asked him, "You feel responsible because **...** ?" He replied, "I should have prevented it."

"Should" is a word that belongs to the category once known as the Imperatives. Now they are renamed as Modal Operators. There are two subclasses of Modal operators - Modal Operators of Necessity and Modal Operators of Possibility. "Should" belongs to the former with ought, must, have to, mandatory and necessary.

It was clear that "I should have prevented it." was the ontological driver for his depression. In that he had failed he had blamed himself for it and he rotted in the guilt of his brother's death. This, in turn was named by his Psychiatrists as Depression.

It was obvious that the modal operator had to be deleted

What then was the treatment?

This was done by taking him through the protocols of the Question of WHY Seminar.

<u>The third was a function of a Time Lock.</u>:

This patient was a woman in her late sixties. She was in a sustained and severe depression of some 7 years.

She and her husband were Canadian snow birds, wintering in their Florida condominium. He was retired.

It was 7 years ago, whilst in Florida that there was a severe altercation between them. It rose to the threshold in which he lost it and said to her, "I wish I never married you!" To this she shot back, "I wish I had never married YOU!" He, in turn was not going to not have the last word, so he

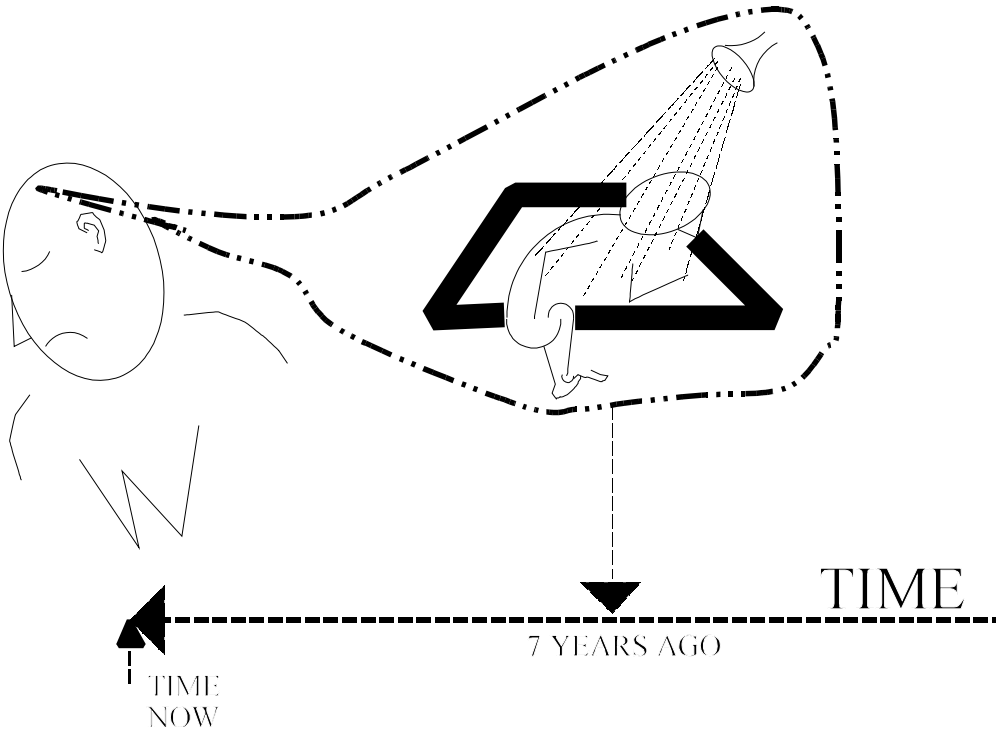
shot back, “I wish you were dead!” She, now, quite beside herself retorted, “I wish you were dead too!” Now she was desperate for a smoke. She was fumbling for her cigarettes but there were none. So she stormed out of the apartment and went downstairs to the shop to buy a packet of cigarettes.

As she lit one, she suddenly stopped herself from returning to the condominium with the thought, “I will just let him stew.” And with that she went out for a walk.

When she returned to the apartment, he was not in the living room. So she went to the kitchen. He was not there. She went into the bedroom and he was not there either. Then she heard the shower. So, he was having a shower. Fine! She went into the kitchen to get herself a cup of coffee. 15 minutes lapsed and he was still in the shower. 30 minutes now passed by and he was still in the shower. When it was 45 minutes, she had enough and went to the bathroom. She opened the shower and there he was lying on the floor of the shower. He was dead.

In the course of the consultation I posed this question to her, “Am I correct to say that the memory of finding him in the shower is still vivid in your mind.” She replied, “Yes, constantly!”

So, it was clear that even though time had moved on, it was now 7 years since his death, her vivid memory of his death had locked her way back then. In the span of the 7 years since his death she had not lived in the NOW.



We represent her predicament in the following manner.

This memory was the mother of her guilt, sadness, grieving and loss. These emotions ate into her and they were psychiatrically named "Depression" for which every and all variant anti-depressive drugs were given to her. Of course they were of no avail. It would have worked if some pharmaceutical company had come up with an anti-memory drug.

What was the treatment?

Three things had to be done. They were to:

1. lever her out of her time lock
2. delete the impact of the memory
3. stop the driver for her emotion.

It is unfortunate that we do not have the time to share with you what the specifics are regarding the therapeutic protocols to accomplish what we did for her as we cited above.

This patient is well today.

Endnotes:

1. sensory based description means to describe a sensory piece of information as it is experienced. This will be clearer as you read further on.

2. **praecordium** is a term that refers to the area of the chest that overlies the heart.

3. a **whole body tiredness** with **loss of visual acuity of internal imagery and external sight** This 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 in Atlanta, Georgia.

4. Pragmagraphics is a sub-field of study in Neuro-Linguistic Programming. It examines the elements that constitute sensory based descriptions and explores how to manipulate them.

5. Question of WHY Seminar is the most power therapeutic algorithm that will end either the perpetual blaming stance of an individual or the craven and fear stance of always having to protect oneself from being blamed or faulted.

6. Gurudev Manouevres are the abstracts from the teachings of the first Jain priest who ever left the Indian subcontinent to teach in the west. They are, by the trial and witness of our clinical experience, the most powerful healing words that we know to utter to patients who have either been violated or traumatized.

7. Virginia Satir was the creator of Conjoint Family Therapy.