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The Ontology of Depression and the Physiology of Depression

by

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Depression is a word in the category of a noun. As a noun, it is an objectification of a process. In English Transformational Grammar it is known as a nominalization of the process "feeling depressed."

This is also true for the term "pain" for as a noun, the word "pain" now stands for the nominalization of the process of "feeling pain."

In Medicine, we treat these two nouns very differently.

In the case of pain, medical practitioners want a sensory-based description of how it is experienced by the patient. Thus, they want to know:

1. the manner of the 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 when it began and how it developed or whether it was constant and remained so throughout its duration
4. whether it remitted
5. its duration
6. when it exacerbated
7. how it exacerbated
8. what the pain was like, i.e. twisting, burning, tight knot, distending, nagging ache, like a weight and so forth
9. whether it was localized or whether it radiated
10. how did it radiated
11. where did it radiate.

To a surgeon or physician, this sensory-based description carries important information. They allow the surgeon to infer the differential possibilities with respect to the pathological basis for the complaint. Thus, the above might suggest a volvulus, an ulcer, an intestinal obstruction, excessive presence of gas, a cancer, a fracture and so forth.

By getting a sensory-based description, the medical practitioner is in effect "de-objectifying" the pain, a.k.a. de-nominalizing the noun back to its process. In doing this, the medical practitioner is implicitly acknowledging that the noun is an artifact of the linguistic manouevre of nominalizing vs the true-to-fact actuality of the process.

However, in Medicine, we treat the word Depression very differently. We do not set out to secure its sensory-based description as represented by the patient. Instead, we set out to surmise what other things are associated with it. In doing this we then finally get a constellation of elements around Depression, thus:

Diagnostic criteria for 300.40 Dysthymia

A. Depressed mood (or can be irritable mood in children and adolescents) for most of the day, more days than not, as indicated either by subjective account or observation by others, for at least two years (one year for children and adolescents)

B. Presence, while depressed, of at least two of the following:
(1) poor appetite or overeating
(2) insomnia or hypersomnia
(3) low energy or fatigue
(4) low esteem
(5) poor concentration or difficulty making decisions
(6) feelings of hopelessness

C. During a two-period (one-year for children and adolescents) of the disturbance, never without the symptoms in A for more than two months at a time.

D. No evidence of an unequivocal Major Depressive Episode during the first two years (one year for children and adolescents) of the disturbance.

Note: There may have been a previous Major Depressive Episode, provided there was a full remission (no significant signs or symptoms for six months) before development of the Dysthymia. In addition, after these two years (one year in children or adolescents) of Dysthymia, there may be superimposed episodes of Major Depression, in which case both diagnoses are given.

E. Has never had a manic episode (page 217) or an unequivocal Hypomanic Episode (see page 217).

F. Not superimposed on chronic psychotic disorder, such a Schizophrenia or Delusional Disorder.

G. It cannot be established that an organic factor initiated and maintained the disturbance, e.g., prolonged administration of an antihypertensive medication.

Specific primary or **secondary type:**

Primary type: the mood disturbance is not related to a preexisting, chronic, nonmood, Axis I or Axis III disorder, e.g., Anorexia Nervosa, Somatization Disorder, a Psychoactive Substance Dependence Disorder, an Anxiety Disorder, or rheumatoid arthritis..

Secondary type: the mood disturbance is apparently related to a preexisting, chronic, nonmood Axis I or Axis III disorder.

Specific early or **late onset:**
Early onset: onset of the disturbance before age 12
Late onset: onset of disturbance at age 21 or later

Diagnostic and Statistical Manual of Mental Disorders (Third Revised Edition) 1987, pages 232 - 233

It is also obvious that we can approach the condition of pain the same manner:

A. Pain (can be very irritable especially in children and adolescents) for as long as it last

B. Presence, while in pain, at least two of the following:
(1) poor appetite
(2) insomnia or hypersomnia
(3) low energy or fatigue
(4) low esteem
(5) poor concentration or difficulty making decisions

(6) feelings of hopelessness

C. If narcotics fail to relieve the pain, the patient can lapse into either an anger state or into a depression

We have chosen to explore what might be the possible unique sensory-based descriptions of the physiology of Depression, to wit, its implicate process. Here are some samples of our findings.

(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

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

(vii) a sense of emptiness in the praecordium. No tiredness and no lack of energy was experienced anywhere in the body

(viii) a very tight discomfort in the area of the private parts

(ix) a body tiredness below the waist and an overwhelming desire to sleep with concomitant heaviness of the eyelids

(x) a whole body tiredness with loss of visual acuity of internal imagery and external sight. A Neurologist offered this last description to us 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.

Are there any consequences to track for a sensory based description of Depression vs a qualitative description of it. We say that there is!

Each sensory-based description indexes a distinct internal physiology. This is so since only a given physiology can sustain whatever it is that the patient is complaining about. In turn it compels the question as to what might be the condition or what has to exist for each distinct and unique different physiology to be extant in a person. We know that this has not happened if we track by a qualitative description of Depression.

In turn, there is much out of human intuitions to suggest that these distinct internal physiologies are by-products of unique internal sentient processings. In turn this compels the clinician to explore what they might be. This line of enquiry is not open to anyone who tracks by a qualitative description of Depression.

Now, to track by a sensory based description of Depression, we are compelled to face its **first mystery** in Depression. As far as we are aware there is no definitive blood test that indexes the diagnosis of a Depression, bipolar or otherwise.

This is a huge subject matter. As far as we know, in the literature, it was first addressed in the work *Power and Elegance in Communication*. It appeared in this work because this book dealt with the impact of language on human ontology, especially the metalanguage of the Non-Aristotelian system of human Relativity and Relatedness. And all changes in human ontology are changes in human physiology. The question was how to track them in the face of the power of homeostasis.

It is only when we track our understanding about Depression in a sensory based way that we have a chance to find the answer to the **second mystery**. This concerns the known variability in the efficacy of anti-depressants when they are prescribed for the clinical condition. An anti-depressant may work wondrously well in one case of Depression but utterly ineffectually in another. At other times it may only has some partial efficacy.

It is our view that when an anti-depressant works, it does so because its chemistry is apposite to the physiology of the Depression as represented by the given sensory based description for the condition. When it fails, its ineffectiveness is because its biochemistry is utterly dissonant with the bio-physiology of the Depression as indexed by its sensory based description.

When we use sensory based descriptions for Depression, we have finally come to understand the **third mystery** about Depression. Researchers have been compelled to examine the nature of "normal" and altered human states. It has to do with how it is that in spite of the order of magnitude and the intensity of the problem in a Depression, the patient is unable to say what he is depressed about. For all practical purposes, to every case one asks, "What are you depressed about?" the answer is invariably, "I don't know." Then:

> Because Meta-States have reference to other states of consciousness, an abstraction of thought-feelings about previous thought-feelings, it moves up the scale of conceptualization and into the world that we construct with our languaging - *The Land of Nominalizations!* Meta-states, accordingly, have much more reference to things *inside* our skin ("things" like ideas, concepts, etc). Korzybski would have called this an *intensional* state.
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> As meta-states continue up the scale into more and more transcendental states, *they become more and more **atemporal** in nature*. This enables us to carry them **across time** in a way that we cannot carry primary states through time. Primary states constantly change. Count on it! If you track your states throughout a day, you will find half a dozen to perhaps three dozen "states" of consciousness that you experience. You can't stay mad, sad, glad or afraid for an extended period of time.
>
> Yet **the atemporarity of Meta-states** do allow us to carry an "attitude" or a worldview disposition with us across time. Thus suppose a person becomes sad about their sadness, and sad about their fear, and sad about their achievements, and sad about their sadness about their sadness? As we developed solidified states about states about states, they become transcendent mind-sets out of which we operate that we can take with us everywhere we go. We may never leave home without self-pity, self-criticism, and undefeatable spirit, etc. Because of this, negative meta-states operate to disempower and sabotage us just as the positive meta-states operate to empower and transform all of life. As meta-level experiences, these meta-states drive the states and experience below them.
>
> This atemporarity of meta-states also make it possible for a meta-state to become a **floater**. This refers to the fact that *sometimes a meta-state becomes detached from everything* - it stops indexing completely. Then it becomes a state meta to every thought, feeling, experience, behaviour, etc. It floats along and above every piece of consciousness. And by so doing this, it becomes the ultimate filter or frame of reference out of which we live. this may serve to enhance life; it may serve to make a living hell.

Michael Hall: *META-STATES* Environment Technologies 1986 page 88 – 89.

In converting the primary state into a metastate, the patient will now not know what he is actually depressed. It is possible retrieve this information. There are choices as to how to achieve the outcome, to wit, by:

1. Barnett manouevre
2. Ideomotor questioning
3. Open ended hypnotic regression
4. Quadrant Search.

Case I:

A lady complained of her unremitting Depression. The therapeutic efficacy of Prozac was minimal.

From our enquiry, we discovered that she and her husband were retired. They were Canadian snow birds. They enjoyed our winters in their Floridian condominium. One winter she and her husband were in an altercation. It became so intense that her husband uttered a disclaimer. It was, "I wish I had never married you." She refused to take this and shot back at him, "I wish I had never married you!" Given that he was not going to have the last word, he decided to up the stakes and blurted to her, "I wish you were dead." She in turn shot back at him, "I wish you were dead!"

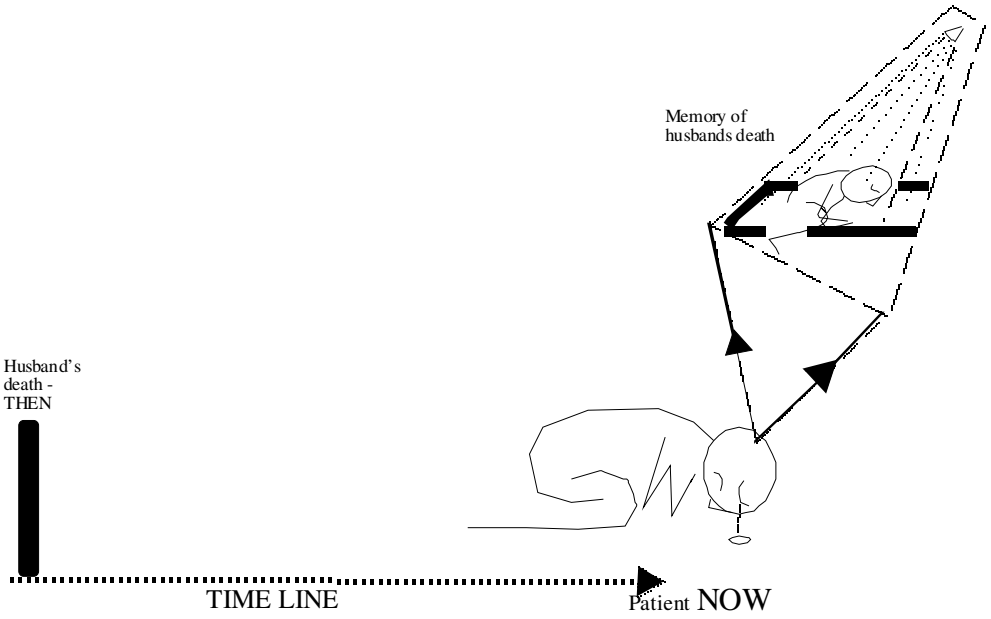
She was now quite upset and beside herself. Her predicament was complicated by the fact that she had run out of cigarettes. She, therefore, stormed out of the apartment to the shop down stairs. When she smoked the first puff, she turned to go into the lift to go up to the apartment. She stopped herself with the thought, "Let his stew." She turned and went our for a walk.

About three quarter of an hour later she returned. When she came into the apartment, he was not to be found, He was not in the kitchen either. When she went into the bedroom she heard the shower. He was having a shower.

She went to the living room to wait for him. Fifteen minutes passed and he still was not our. Half an hour later he was still in the shower. When it came to forty five minutes, she had enough. She went into the bedroom and then in the bathroom. She opened the shower door. He was on the floor, dead.

I asked her, "Is it true that to this day you still see him on the shower floor **VIVIDLY**." She replied in tears, "Yes."

For us, the diagnosis was obvious.



The diagram indexes the existence of a Time Operator that compels the condition for her to generate vividly the memory of finding her husband in the shower floor.

The treatment of her condition was to delete the Time Operator. Once this was done, it was the end of her condition for her continuing to feel depressed. She was therefore able continue to live her life in a full way without any need to take anti-depressants.

Case 2:

This was a man in his mid thirties. He came complaining of a Depression that had not remitted with the use of anti-depressant medication. In fact he complained that they really had done nothing for him.

In the process of gathering the information, he shared with us that he had a brother who committed suicide when he was in his early teens. We asked him how he felt about his brother's suicide. To this he replied, "I have always blamed myself for his death because I felt that I should have prevented it."

I was quite stunned to hear this. It meant that:

1 He had lived under the duress of a terrible belief in the form of "self-blame" that he was responsible for his brother's death.

He had assumed complete responsibility for his brother's act of killing himself since an extension of this belief that he "could" have prevented it and therefore he "should" have done so.

It was, therefore, clear that his depression was a function of his Modal Operator. We have a manouevre-in-therapy to delete the operation of the Modal Operator. We call it the Freedom Seminar:

Once this work was applied to him, the operation of the Modal Operator ended. With it his Depression ended.

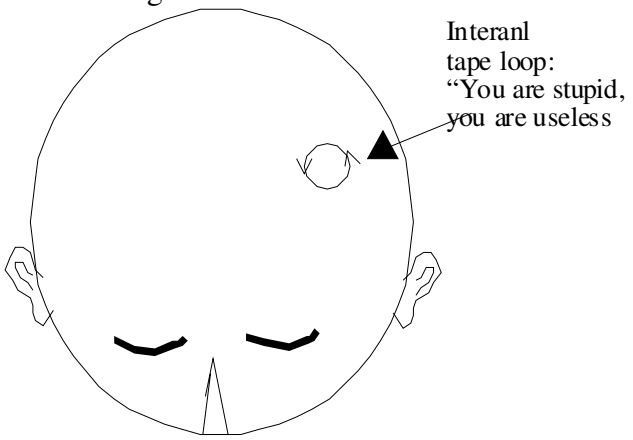
Case 3:

This was a man in his late forties. He had suffered from Depression, on and off, "all my life." The gathering of information initially did not reveal anything unusual.

However, as we proceeded to work with him, we were compelled to enquire further into his case history. He then revealed that he had a father "of the old school." Whenever he did anything that was not it should be according to his father he was told. "You are stupid, you are useless."

We then asked him, "Do you still hear your father saying this to you now?" He checked and confirmed that he could still hear his father saying this to him. It was not as loud as in real life, but it was still said with the same intensity and rigour. We asked him where he heard it. And his left had located the site of the his fathers voice in the left parietal area.

Here then was a depression that was a function of a negative internal auditory tape loop. We shall represent it in the following manner.



The removal of this internal voice loop is a very simply matter. With it, his Depression ceased to be.