To our wives,
Mary Alice Minirth and Jan Meier
who make happiness a much easier choice
and to our parents who nourished
us in love, discipline,
and Christian principles
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Foreword

I often recall a colleague, an eminent and very well-known psychiatrist, who entrusted his daughter to my care after she had attempted suicide. In a letter to me, my colleague wrote that he was not a believer, but his daughter was, and that he thought a believer like me was best equipped to help her resolve her difficulties.

My colleague was much more of an expert than I, who am only a simple general practitioner. In a way, then, this was a matter of an act of faith regarding faith. Thus, even an unbelieving doctor may consider faith to be a factor in recovery.

How does it happen that there are so many depressed individuals among the most fervent believers? And also, how does it happen that so often their faith, which (as my colleague thought) could be a factor in recovery, appears to further complicate their case, because they reproach themselves for their depression, as if it were a matter of lack of faith?

We see how these relationships between spiritual life and psychological health are subtle and delicate. They must be envisioned in their complexity. We must take account of the importance both of religious life and of the pathological phenomena which science studies.

Too often there is a tendency to place faith and science in opposition to each other instead of joining them. Some misjudge the role of faith in destiny, and others misjudge the role of maladies which strike believers as well as unbelievers and which science discloses. The sick and the healthy need to be enlightened on this double aspect of life.

Frank B. Minirth and Paul D. Meier, Happiness is a Choice
(Unpublished manuscript—copyright protected Baker Publishing Group)
Foreword

It is the merit of this book by my two American colleagues that they have dealt with this double aspect of life in a manner so serious and clear that it is accessible to everyone. Here is a book which will help all depressed individuals to better understand themselves and thus to contribute to their own recovery. But this book will also help those who are healthy to better understand the depressed, who so often have the feeling of being misunderstood or misjudged by those who are healthy. This will in turn be favorable to the recovery of the depressed.

Anyone who reads this book will gain a better knowledge of the laws of life which are divine, so that he may better conform to those laws.

What is it that science studies, if not the laws of nature, the laws established by the Creator over His creation? And the first law of God is love! Like the authors of this book, I hope that every reader finds in these pages an opportunity to approach both God and good health.

Geneva, June 23, 1978
Paul Tournier

For further information regarding the nationwide services of the Minirth Clinic, please call 1-888-646-4784.

To reach the Meier Clinic nearest you, please call 1-888-7-CLINIC or you may reach us at www.meierclinics.com.
I would like to initiate the reader on his or her journey through this book by breaking tradition and sharing some of my personal, innermost reflections. As I write this I am sitting calmly in a waiting area at the Dallas/Fort Worth Airport. As I gaze out the windows, I see the large cumulus clouds gently floating by as the airplanes mechanically come and go. I feel an inner joy and excitement. I feel at peace with God, at peace with my wife and children, and at peace with the friends I love so dearly. And yet, as I am looking around this waiting area and analyzing (as we psychiatrists love to do) the people sitting around me, I have a somewhat different inner feeling. As I search for ways to describe it, I think of the word angst—a term present-day German philosophers and theologians are tossing around. Angst is a type of undefinable inner anxiety. As I look around right now and think about the condition of my fellow man en masse, I feel angst. In my practice of psychiatry I counsel many individuals from that mass of humanity; I have come to understand the repressed fears, insecurities, and anger within many of them, sometimes even hidden behind smiling faces. I understand and I empathize. In fact, I not only empathize, I hurt for them deep within. I want them to know the things I have learned that have brought me great personal joy and inner peace. That is why Dr. Frank Minirth and I feel compelled to write this book—to share what we have learned with you, the reader, in hopes that you will in turn pass it on to others you love.
Many years ago I read a very thought-provoking statement made by Abraham Lincoln: “Most people are about as happy as they choose to be.” I couldn’t agree with him more. Lincoln should know. He went through much anguish in his life—the death of his fiancée, lost elections, the Civil War, and other major disappointments. At one period of his life he was so depressed he considered suicide. But Lincoln chose to overcome his depression. He chose to be happy and obtained inner joy and peace in those last years before he fell victim to the bullet of a hostile fellow man.

Before you decide to agree or disagree with Lincoln’s assertion that “most people are about as happy as they choose to be,” or with the authors’ assertion that “happiness is a choice,” let me explain what the title we have selected means. My associate and I have a combined post–high school education totaling over thirty years. During that time we thoroughly researched man’s psychology, physiology, anatomy, mentality, and spirituality. We have also exercised our psychotherapeutic skills on thousands of patients. Both of us can say with a deep inner conviction that a majority of human beings do not have the inner peace and joy about which I am thinking. We are also convinced that all human beings are capable of having this inner joy and peace if only they will choose it and follow the right path to obtain it. Please don’t get me wrong. Most depressed human beings wish their depression would go away but do not know the paths to happiness. Others may actually choose depression as a lifestyle because a traumatic past has misled them to believe they deserve a life of depression. Some have a genetic depression that only lifelong medication will relieve, but choosing to take medicine when needed is a choice that can be life-changing for the better.

It is difficult for many laymen to comprehend that anyone would choose unhappiness and depression over peace and happiness, but many people do so for a variety of reasons of which they are unaware. Some choose unhappiness to punish themselves for guilt feelings. Adults who were abused as children, for example, erroneously learned that they must be “trash”—that they must deserve to be abused somehow. Their false guilt and bitterness result in lifelong depression until they learn the truth about their own value and release their unconscious areas of bitterness. Others choose unhappiness to manipulate their mates.
Inner Reflections

and friends by enlisting their sympathies. Other inner motivations for remaining depressed will be analyzed later in this book.

As a point of clarification, Dr. Minirth and I are convinced that many people do choose happiness but still do not obtain it. The reason for this is that even though they choose to be happy, they seek for inner peace and joy in the wrong places. They seek for happiness in materialism and do not find it. They seek for joy in sexual prowess but end up with fleeting pleasures and bitter long-term disappointments. They seek inner fulfillment by obtaining positions of power in corporations, in government, or even in their own families (by exercising excessive control), but they remain unfulfilled. I have had millionaire businessmen come to my office and tell me they have big houses, yachts, condominiums in Colorado, nice children, a beautiful mistress, an unsuspecting wife, secure corporate positions—and suicidal tendencies. They have everything this world has to offer except one thing—inner peace and joy. They come to my office as a last resort, begging me to help them conquer the urge to kill themselves. Why? The answers are not simple. The human mind and emotions are a very complex, dynamic system. In this book we will do the best we can to summarize some of these complexities in layman’s terminology and offer guidelines, step-by-step, for obtaining lasting inner happiness—if you choose it.

Now I am floating in a large jetliner thirty-five thousand feet in the air and high above those enormous cumulus clouds I watched float by a short time ago. I am heading for Los Angeles to address a weekend retreat of physicians and their wives. I have been asked to teach them what I know about sources of emotional pain in physicians and their families. They are taking this weekend off from their busy schedules to find out how to obtain inner peace and joy. I respect them for that. Physicians and dentists have the highest suicide rates in our current American culture. They are overwhelmed with pressures, which they perceive as being external. In reality, their overwhelming pressures are primarily from within—from perfectionistic, masochistic, self-critical inner drives and insecurities. Many of them have an enormous fear of failure and a strong need to rescue the world from illness and death. That is why Schulz, in his “Peanuts” comic strip, refers to the MD degree
as the “M. Deity” degree. Most physicians (including Dr. Minirth and myself) go into medicine because of their compassion for a suffering mankind. At least, that is their conscious motivation for entering medicine. Many physicians, unfortunately, experience a phenomenon known as “burnout”—a loss of human compassion due to the strenuous demands and regimentation of medical school, internship, residency, and private practice. Many of my current psychiatric patients are fellow physicians from other specialties who are depressed and suffering from considerable emotional pain.

As I fly over the beautiful western states between Texas and California, I am feeling angst for those physicians and their wives waiting for me in Los Angeles. I am pondering not only what I am going to share with the physicians and their wives at the retreat but also what I can share with the readers of this book. In regard to the latter I see two primary tasks lying ahead of me. My larger task (though this may seem incredible) is to persuade the reader to give up his depression and choose happiness. This sounds ridiculous to many people who do not understand the complexity and depravity of human nature. But it is true, nevertheless! Depression meets many unconscious neurotic needs. When patients come to me and tell me they have been depressed for many years and that they have had enough of their depression, we sit down together and analyze what rewards they have unconsciously been getting by unwittingly choosing years of depression. The unconscious motives vary from person to person, but they invariably revolve around the emotion of anger—repressed anger—and holding grudges against self, others, or God (these concepts will be discussed later in this book). After analyzing why they are depressed, I attempt to persuade my patients to choose happiness.

The second task is to persuade the reader to commit his life to the correct course for obtaining inner love, happiness, and peace. People get very set in their ways. Even when they have tried their ways for twenty or thirty years with no lasting results, they still cling to their childhood behavior patterns. Many alcoholics, for example, are surprised to find out that when they give up drinking and become responsible family men, their complaining (and controlling) wives divorce them and marry other alcoholics because their fathers were alcoholics, so
they have become addicted to the codependent patterns of their family of origin. I see this repeatedly! Our brains are very much like complex computers, as behavioral research is demonstrating today. Most people choose to continue in the behavior patterns their parents correctly or incorrectly programmed into their computer-brains in early childhood. In an earlier book (Christian Child-Rearing and Personality Development, Baker, 1977), I fully demonstrated and documented my belief that approximately 85 percent of our behavior patterns and attitudes are firmly entrenched by age six. I am not saying that we are permanently locked into those childhood behavior patterns and there is nothing we can do about it—it is just that most humans ignorantly choose to stay locked into those early childhood behavior patterns and worldviews. Thank God that He created within us a human will. When He created us in His image, He gave us a will—an ability to choose. Without the power of the will, the efforts of psychotherapy or even writing this book would be worthless. I am hoping and praying that you—the reader—will exercise your God-given will in choosing some new, health-producing attitudes and behavior patterns. Your happiness is my goal. But I have no power at all to make anybody happy except myself. All I can do is to persuade the reader that he should choose happiness and to point out what I believe to be the correct paths to obtain it. It is then up to him to choose and follow those paths.

Paul Meier, MD
1978

Further Reflections

It is now 1994, and sixteen years have passed since Dr. Frank Minirth and I wrote this book. Happiness Is a Choice continues to help thousands of men and women to begin the process of developing a more productive and joyful lifestyle. The book is even used now by many missionaries throughout the world, predominantly in areas where competent psychiatric help is not available (especially from a Christian perspective).

The principles we wrote about in 1978 still work just as well today, because human nature is human nature. Trends change, but human nature
and basic behavior patterns have repeated themselves for thousands of years. However, Dr. Minirth and I felt an urge to revise *Happiness Is a Choice* in 1994 in order to explain some more recent medications and some new research findings on depression, including some additional genetic factors and codependency factors.

We appreciate the thousands of letters we have received from readers of *Happiness Is a Choice*, because the letters have pointed out places that were misunderstood by some. In the revised version, we have attempted to clarify those misunderstandings.

We hope God will continue to use this book to help nonbelievers to find faith in Him and to help believers to become more effective servants for Him. The ultimate goal of the Christian should not be happiness here on earth—it should be to serve God and our fellow man by becoming increasingly able to love and be loved and to serve in love. But how effective is a depressed Christian? Love and joy are “fruits” of the Holy Spirit. We want to help every human being find true happiness and meaning in life in the midst of the inevitable pains and chaos that are a part of every life in this fallen world.

Paul Meier, MD
1994

**Inner Reflections 2007**

*Is happiness a choice?* I asked that rhetorical question in 1978 in the first printing of this book. The answer catapulted this book to perhaps the best-selling volume of all time on happiness. Why? The book was informative, pragmatic, and passionate for Christ; its topic covered a range of people—from those with no depression who just wanted more happiness to those with significant, even severe, depression. Obviously *Happiness Is a Choice* hit a nerve in Christianity.

Why are people unhappy? For a plethora of reasons—loss, hurt, failure, finances, pain, job, relationships, changes, poor choices, genetic factors, and childhood issues. Some are unhappy due to a medical condition, some have a physiological proclivity toward depression, and some have never known happiness. This book offers assistance to all of the above.
Do I still believe we can make choices in life that produce health and happiness? Absolutely. When I was growing up, my family attended a small evangelistic church that placed a tremendous emphasis on choice. In my memory I can still see the little white church in a grove of trees in the country, and my mind still reverberates with the hymns we sang about free will. Many years later I attended a seminary that emphasized the sovereignty of God. Do our free will and God’s sovereignty exist only as a paradox? The Bible teaches both. They do not negate one another.

The Bible certainly teaches the sovereignty of God, but it also teaches the concept of our freedom to choose. God’s sovereignty does not preclude man’s choice. The best-known verse on choice is Joshua 24:15 (NKJV): “Choose for yourselves this day whom you will serve. . . . But as for me and my house, we will serve the Lord.” Another interesting verse on choice is found in the New Testament: “But one thing is needed, and Mary has chosen that good part, which will not be taken away from her” (Luke 10:42 NKJV). A third great verse on choice is found in Deuteronomy 30:19 (NKJV): “I call heaven and earth as witnesses today against you, that I have set before you life and death, blessing and cursing; therefore choose life, that both you and your descendants may live.”

Have you ever felt depressed? In the following pages, you’ll discover choices you can make—choices that will help you overcome depression when stresses of life weigh on your shoulders. Have you ever felt beaten down by the storms of life and doubted whether you can bounce back? Many people never reach happiness because they believe they are incapable of being happy. The reality is, we can do whatever Christ wants us to do. With His help and our healthy choices, happiness is ours for the taking. Just today, a man said to me, “Eight years ago I was unhappy; I read Happiness Is a Choice. I made those choices and they made all the difference.”

Am I a happy person? Yes. I feel happiness being around my wife, Mary Alice, and our girls. I feel happiness doing the ministry God has given Mary Alice and me. I have lived out the choices described in Happiness Is a Choice; they do work.

What is happiness? Socrates thought it was knowledge, and he taught Plato who taught Aristotle who taught Alexander the Great—but none
seemed able to obtain this elusive concept of happiness. Freud thought it resulted from insight; Pavlov thought it could be conditioned; Piaget believed cognition held the key; James believed pragmatism produced happiness; Rogers believed understanding was important—but no one approach quite captured it. The dictionary offers a denotative meaning of happiness as “a subjective sense of well-being,” but this seems to grossly lack in a connotative sense. Perhaps happiness is best defined as a process—a process that involves a series of choices.

What were those famous choices from the 1978 printing of Happiness Is a Choice? Here is the quintessence of those choices:

1. Be kind—show Christlike love.
2. Focus on healthy behavior.
3. Challenge inaccurate thinking with the Word of God.
4. Share hurts.
5. Meet dependent needs through Christ and the local church.
6. Consider the medical.
7. Emphasize Christ and His teachings and example.

Yes, happiness is a choice.

The following pages elucidate those seven choices in a manner that hit a nerve in Christianity when first released. The book Happiness Is a Choice continues to flourish. Because of its never-ending popularity, I thought I should update the medical information because medical knowledge continues to proliferate. The original light of truth from the Scriptures remains; the same common sense found in the specific behavioral suggestions of the original volume endures in this one.

What is new in regard to depression in this book? The medical data in appendix 3 is 50 percent new and redoubtable. I recommend you carefully consider this latest information; it is instructive for all and may be lifesaving for some. Appendix 3 presents the avant-garde of knowledge regarding depression. Read it and gaze into the future.

I believe happiness is a process, a series of choices; I believe happiness is a choice, indeed, your choice for the taking.

Frank Minirth, MD
2007
Inner Reflections 2013

Thirty-four years have now passed since *Happiness Is a Choice* came out in 1978. Dr. Minirth and I have, together or separately, written well over a hundred books that have sold more than 7 million copies in more than twenty languages. We have great joy from the knowledge that God has used *Happiness Is a Choice* and our other books to improve the quality of life in so many millions of people.

Years ago, for example, I was flying home alone from one of my trips to Israel to train counselors there. I sat by people who could not speak English on my Tel Aviv–to–Paris flight and was lonely and bored. I like to fellowship with people, so I prayed before I got on the long flight from Paris to Chicago, “Lord, please put somebody beside me who speaks English so I won’t die of boredom!” An attractive and pleasant thirty-year-old Frenchwoman from Paris sat beside me and spoke pretty good English. I said thanks to the Lord and asked Him to keep my thoughts pure! Without sharing our names I asked her where she was going. She was going to Little Rock, Arkansas, for vacation. I told her that Little Rock is a beautiful city, but asked why someone from Paris was going to Little Rock for vacation? She said that ten years earlier, she had suffered a severe depression while in college in Paris, and a missionary from Little Rock gave her a book by Dr. Paul Meier and his partner called *Happiness Is a Choice*. Trying not to look surprised, I told her slyly that I had heard of that book, not telling her I wrote it. She said as a result of that book, she not only recovered from her depression but became a believer and was now a missionary to college students herself near Paris. She was going to Little Rock to visit the lady who gave her *Happiness Is a Choice* ten years earlier and also to hunt down Dr. Paul Meier.

Startled, I asked her why she wanted to “hunt down” Dr. Meier. She said the other missionaries in Paris had asked her to do so to get his advice on how to get more training in order to better counsel the many students they were helping. At that point I told her I was Paul Meier, and when would she like me to come to Paris to train the missionaries and other interested people there? She thought I was joking until I pulled out my passport. It was a divine appointment, and a few months later
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I was in Paris training not only those missionaries but also professional therapists, pastors, and others.

I feel certain that if you read this book, it will help you to have a better quality of life and spirituality. I also believe you will be able to use what you learn in this book, like my French new friend did, to benefit those you love and communicate with the rest of your life.

Paul Meier, MD
2013
What Is Depression?
Who Gets Depressed?

Then the Lord said to Cain, “Why are you angry? And why has your countenance fallen?”

Genesis 4:6 NASB

A young lady whom we had never seen before was waiting in our reception room. She was invited into one of our offices and asked about the nature of her problem. Immediately she burst into tears and related how depressed she felt. She said she felt blue, sad, hopeless, and helpless. Life was not worth living. In short, she felt very anxious and desperate. She had been praying that we would be able to help her, and her tone sounded as though she felt we were the last hope.

This young lady was suffering from America’s number one health problem—depression. As psychiatrists we see more people suffering from depression than from all other emotional problems put together. A majority of Americans suffer from a serious, clinical depression at some time during their lives. At the present time, one American in twenty is medically diagnosed as suffering from depression.1 Of course, many, many more are depressed but never receive help. According to one estimate, about twenty million persons in America between the ages of
What Is Depression?

eighteen and seventy-four are currently depressed. Depression is the leading cause of suicide; in fact about 15 percent of those people who are significantly depressed will eventually commit suicide. Suicide is the tenth leading cause of death in America today, and it is the second leading cause of death among college students. Depression occurs two times more often in females than males, and it occurs three times more often in higher socioeconomic groups. Money definitely does not buy happiness! Depression occurs most often in the fourth and fifth decades of life, but may occur during any stressful period from infancy to old age.

Depression is a vague term. Laymen use it to describe a wide spectrum of behavior—anything from a mild swing of mood to psychosis. We all fit into that spectrum somewhere, and to some extent our degree of depression versus happiness varies from hour to hour and day to day. As psychiatrists, we treat people who are “clinically depressed”—that is, so depressed that they are having physiological symptoms.

Depression has been discussed from the time of Job to the present. Ever since the symptoms were first recorded, they have remained the same. The Bible records the depressive symptoms of such men as Job, Moses, Elijah, David, and Jeremiah. In the 1600s, Richard Burton wrote a classic book on depression—The Anatomy of Melancholia. In the twentieth century, well-known authors such as Freedman, Solomon, Patch, Eaton, Peterson, Arieti, Kolb, and others have described in detail the symptoms of depression. Many of the symptoms they have described are listed in the next chapter.

Who gets depressed? At some period of life, nearly everyone does! Our strong contention, however, is that people who are suffering from a serious clinical depression can find hope that there is a way out of the pain. Depression (without biological causes) is usually curable with the right kind of therapeutic help. And for those who have experienced a serious clinical depression, we also want to offer the hope that future clinical depressions are avoidable. Even depression caused by biological reasons, although not curable, can generally be managed with proper medication and counseling. We wrote this book to stop the pain in those who are currently hurting and prevent as much pain as possible for all of us as we face almost certain trials and stressors in our lives at one time or another. Happiness can become a way of life if we choose the right paths to obtain it.
What Are the Symptoms of Depression?

Depression is a devastating illness that affects the total being—physically, emotionally, and spiritually. The emotional pain of depression is more severe than the physical pain of a broken leg. Unlike a broken leg, however, the pains of depression come on much more gradually and last much longer. Many men and women are currently suffering from numerous symptoms of depression without even realizing that they suffer from depression rather than from some purely physical illness. The symptoms of clinical depression fall into five major categories: sad affect, painful thinking, physical symptoms, anxiety, and for some, even delusional thinking.¹

Sad Affect (Moodiness)

One major symptom of depression is a sad affect (or moodiness). An individual suffering from depression has a sad facial expression. He looks depressed. He either cries often or feels like it. His eyes are cast down and sad. The corners of his mouth droop. His forehead is wrinkled. He looks tired, discouraged, and dejected. His features are strained.
What Is Depression?

As the depression progresses, he gradually loses interest in his personal appearance. Sometimes men even stop shaving and women stop putting on their makeup. Thus, the seriously depressed individual frequently appears untidy. Even if he tries to hide his depression by smiling, it still shows. In fact, many depressed individuals have what is known as a smiling depression. Many men and women smile inappropriately to cover up the sad or angry feelings within.

Painful Thinking

A second major symptom of depression is painful thinking. As surely as a broken arm is painful physically, so the thinking of a depressed individual is painful emotionally. Many persons who have experienced both severe physical and emotional pain have stated emphatically that emotional pain is worse than physical pain. They would prefer broken bones to a broken heart! The depressed individual is very introspective in a self-derogatory way. He ruminates a great deal over past mistakes. He often feels guilty, even when innocent. He may feel responsible when he is not. He feels at fault when blameless. He worries excessively over all kinds of wrongs in the past, both real and imagined. His thoughts are self-debasing. He has a negative self-concept. He has an exaggerated view of his problems and frequently blames himself for all of his problems (some depressed individuals go to the opposite extreme, however, and inappropriately blame others for all their problems as they wallow in self-pity). He tends to view himself as being deficient in qualities that he considers important, such as popularity, intelligence, or spiritual maturity. He feels blue, sad, helpless, worthless, and hopeless. (In fact, 75 percent of depressives feel they will never recover.) He often feels deprived of emotional support and thus feels empty and lonely. He craves affection and reassurance from others, but often his deep-seated hostility frustrates his purposes. He is filled with remorse for imagined wrongs, both recent and remote. He is unhappy and pessimistic. He may become petulant and distrustful. His every experience is combined with his mental pain. He is preoccupied with himself. He is self-possessed. He is absorbed with a few topics of melancholic nature. He anticipates nonacceptance from others and feels rejected and unloved, usually
significantly out of proportion to reality. He is so occupied with himself and his ruminations that his attention, concentration, and memory are impaired. He feels anxious and perplexed. To him the future is gloomy. He experiences a low energy level and a sense of futility.

As we have stated above, the painful thinking often centers around guilt. The guilt may be true guilt, but often for the depressed individual false guilt is also a significant problem. He feels guilty when innocent. He feels guilty for many minor mistakes and wrongs. Most individuals have suffered from guilt for brief periods of time after doing something wrong (the only exception is a sociopath or a criminal). Thus, most know how painful guilt is for even a brief period. Imagining how painful it would be to live with a constant haunting guilt can help one to understand how miserable the depressed individual feels. He has guilt which he thinks he cannot escape.

The painful thinking of the depressed individual centers around taking on responsibility for acts and events which, realistically, are outside of his control. This may have its genesis in man’s need to feel important. The depressed individual has an overwhelming sense of inadequacy and has feelings of worthlessness. He feels as though he is a nobody—a zero. However, he refuses to be a nobody. He surely cannot be a zero if he is responsible for a great many events and acts—if so much hinges on him. Thus, in a warped sort of way, his feelings of overwhelming responsibility protect him unconsciously from his feelings of worthlessness. They give him a great sense of power. In many ways he becomes omnipotent as a reaction against his true inner feelings of inadequacy and emotional impotence.

The depressed individual is characterized by motivational disturbances. That is, he lacks motivation. He loses interest in the types of activities in which he was previously involved. He begins to avoid people and wishes to be left alone. He loses his sense of humor. He becomes indecisive. Eventually, he becomes suicidal.

Physical Symptoms

A third major category of the symptoms of clinical depression includes the physical symptoms, which are known by medical doctors as
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the “physiological concomitants of depression.” Actual biochemical changes involving the brain amines, especially serotonin, take place in the human nervous system during clinical depressions. Our brain runs on serotonin the way that our cars run on gasoline. These biochemical changes have various physical results: The body movements of the depressed individual usually decrease. The quality of his sleep is affected. He may have difficulty falling asleep at night, but more often he suffers from waking up too early in the morning. After waking up early he has difficulty going back to sleep. This is a frequent occurrence. Initially, rather than sleeping too little, he may sleep too much. His appetite is also often affected. He either eats too much or too little (usually too little). Thus he may have either significant weight loss or weight gain. He may suffer from diarrhea, but more frequently from constipation. In women, the menstrual cycle may stop entirely for months, or it may be irregular. There is often a loss of sexual interest. The depressed individual may suffer from tension headaches or complain of tightness in his head. Along with slow body movements, he may have a stooped posture and seem to be in a stupor. He may have gastrointestinal disturbances. He may have a slow metabolic rate. He may suffer from a dry mouth. A rapid heartbeat and heart palpitations are fairly common. These physiological changes scare most individuals into hypochondriasis (an overconcern with physical illnesses). Many erroneously become convinced that they have cancer or hypoglycemia or a nutritional disorder. Actually, they would prefer to have a physical illness in order to save face. They hate to admit that they have psychological conflicts, which they view as weakness. Out of over one hundred patients who came to us thinking they had hypoglycemia, only one of them actually had borderline low blood sugar as determined by a six-hour glucose tolerance test.

Anxiety or Agitation

A fourth major symptom of depression is anxiety or agitation. Anxiety and depression usually occur together. The depressed individual feels anxious and often is more irritable than usual. Also, as depression increases, so does agitation. The depressed individual feels tense and has difficulty sitting still. Many depressed individuals develop panic
attacks—bouts of extreme anxiety. They may even have such rapid heart rates that they think they are having heart attacks.

**Delusional Thinking**

A fifth major symptom that *can* occur in very severe depressions is *delusional thinking*. It differs from painful thinking only in degree—the delusional thinker is clearly out of touch with reality. His delusions involve either notions of persecution (e.g., he thinks people are out to get him) or grandiose assumptions (e.g., he thinks God has given him some special gift or insight). He may have *auditory hallucinations*—he hears voices that are often condemning and accusing in nature. The voices, of course, are not really there. He may also have *visual hallucinations*—he sees things that no one else sees. He may misinterpret these as visions from God. If he is treated soon after his break with reality, he is usually restored to normality, once again thinking clearly and happy with life. In such cases one or two months of hospitalization may be needed, with daily psychotherapy, antipsychotic and antidepressant medications, and encouragement. Unfortunately, some persons do become permanently psychotic.

In summary, a true clinical depression is a complex, painful disorder involving our total being—mind, body, and spirit. There can be a wide range of severity—from a sad affect and painful thinking all the way to complete loss of contact with reality (a psychotic break) in order to compensate for the extreme pain of reality. Most clinical depressions do *not* reach the psychotic stage. However, most clinical depressions do include a sad affect, painful thinking, physical symptoms (the physiological concomitants of depression), and anxiety (or agitation). If these symptoms disable the individual biologically and socially, he has a clinical depression. Anyone can be cured of a clinical depression if he becomes actively involved in good-quality professional psychotherapy. If the depressed individual has considerable anxiety along with his sad affect, painful thinking, and psychomotor retardation (slow body movements, but with periods of restlessness), he has agitated depression. This is also totally curable. However, if the depressed individual
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in addition has delusional thinking or hallucinations, he has a psychotic depression. Psychotic depressions are usually curable if caught fairly early, although they are much more difficult to treat. Some psychotic depressions worsen and become lifelong schizophrenic disorders. Medical science has recently come up with some breakthroughs so that even some “incurable” schizophrenics may be restored to a rational life by taking lifelong medications.

A Self-Rating Depression Scale

Anyone who answers “true” to a majority of the following statements is almost certainly depressed and should seek professional assistance before the depression worsens.

1. I feel like crying more often now than I did a year ago.
2. I feel blue and sad.
3. I feel hopeless and helpless a good part of the time.
4. I have lost a lot of my motivation.
5. I have lost interest in things I once enjoyed.
6. I have had thoughts recently that life is just not worth living.
7. My sleep pattern has changed of late. I either sleep too much or too little.
8. I am losing my appetite.
9. I am too irritable.
10. I am anxious of late.
11. I have less energy than usual.
12. Morning is the worst part of the day.
13. I find myself introspecting a lot.
14. When I look at myself in the mirror, I appear to be sad.
15. My self-concept is not very good.
16. I worry much about the past.
17. I have more physical symptoms (headaches, upset stomach, constipation, rapid heartbeat, etc.) than I did a year ago.
18. I believe people have noticed that I do not function as well at my job as I did in the past.