What We Need to Know About Depression When Self-inflicted Death Occurs

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Some of the questions certain to be raised when the death of a Christian appears to be self-inflected are whether or not it constitutes a sin and what are the consequences in this world and the next. I will leave this dialogue to the theologians with one word of caution: Anyone who claims to understand fully the mind of God is providing evidence of his or her own spiritual immaturity. And the psychologist who claims to understand the human mind is providing evidence for the limits of his/her own.

The following are the perspectives of a Christian who seeks to integrate the best of theology and psychology in the practice of psychotherapy. The following statements represent my perspective of issues people need to consider when self-inflected death is suspected:

1. Not every death that looks like a suicide is, even when the best of forensics are available.
2. Due to the disabling power of depression not everyone who chooses to end one's life (a) knows he/she is doing so, or (b) understands the impact of his/her death on others. The same condition that leads them to irrationally attempt to end life when there are alternatives denies this person the capacity to fully grasp the finality of the attempt or the pain others suffer from this decision. There are cases when one is attempting to punish someone/s, but even then there is an irrational willingness to die to accomplish this goal.
3. Depression is a complex condition impacting one's thoughts, behaviors, body chemistry and relationships. Amazingly it usually responds well to treatment, but not always. Mood Disorders are divided into two major categories, Depressive Disorders and Bipolar Disorders, each of these are subdivided into many types and combinations of symptoms. A careful assessment is needed to separate out depressive symptoms in order to address them effectively.
4. There is no such thing as a "non-chemical" depression. Components of depression are measurable in a laboratory. The biochemical dimensions of depression have predictable implications for the body, the brain and even the quality of relationships. Healthy cognitive processes (thinking) are dependent on healthy chemistry of the body and brain. Even in "situational" depression the brain chemistry is altered. Some studies have shown that the brain is permanently altered by traumatic events.
5. Some types of depression are strongly related to genetics and represent a higher risk for those whose parents and/or grandparents suffered from depression. It is important in treatment of depression to have a thorough family medical history.
6. Some types of depression are directly related to one's appraisal (perception) of certain stressors or events/circumstances in the environment. The nature and duration of such stressors as well as the coping skills developed by that person determine the person's capacity to overcome them. This type of depression responds well to cognitive-behavioral therapy.
7. All humans experience some degree of mood swings, but some of us are hardwired with a very low threshold or tolerance for stress. When one is biologically predisposed to depression they may be demonstrating extraordinary courage to function without any obvious signs visible to the rest of us. The mind has a tendency to do what one theorist calls "awfulizing." I describe this downward, spiraling, negative thinking process as a *negative thought chain*. Each thought intensifies and triggers the next, each of which is "more awful" than the previous one. If not treated some people will reach a self-destructive state and be unable to recover. This "death spiral" can often be reversed if the therapist is involved soon enough.
8. Antidepressants can be very helpful to some people when prescribed and monitored correctly. Often it involves several attempts with various medications, or combinations of meds, at varying

dosages to find what works for a particular patient. Psychotherapy should accompany any medical protocol. Some depressive conditions require permanent medication management in order to correct a biochemical imbalance and make psychotherapy possible.

9. Perhaps the most destructive of all perceptions among well-meaning Christians is that depression is the result of a lack of faith in God: *If this person would just exercise their faith and truly believe they would "snap out" of the depression.* Perhaps the second most destructive belief is that the depressed or suicidal person is simply too self-centered, as if they were *willingly choosing* to be self-occupied. Because a major symptom of depression is withdrawal, a lack of physical and mental energy, many people describe the depressed individual as "lazy." We would not do so were it cancer or heart disease, but we fail to grasp the truly medical/physical nature of depression.
10. Sometimes neither psychotherapy nor medical intervention will prevent self-inflicted attempts to end one's life. I have seen lives saved by intervention and therapy, both in outpatient and hospital settings. I also had a patient leave the hospital after a highly regarded team determined he was sufficiently recovered to warrant a discharge. He drove his car from the hospital to a remote area and ended his life the same day. While professionals and family members may second guess themselves, even the best care does not always keep someone alive.
11. I once heard a renowned pastor say that in the end only the truth truly blesses. I counsel family members not to attempt to hide what is reasonably known to be a self-inflicted death. I especially believe this is true of high profile leaders who have made huge contributions to our lives. It is important for mature adults to know that even great leaders can succumb to illness. While known as a mental condition, depression is as much a physical illness as diabetes, heart disease or cancer, and sometimes just as lethal.

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