CASE REPORT

Understanding Treatment-resistant Depression: A Missionary's Autobiographical Case Report

Hunter York[a]

[a] Cross-cultural Development Worker, Philippines

Abstract

As a career cross-cultural missionary in Southeast Asia, the author has seen first-hand and has personally experienced the devastating effects of colleagues, families, leaders, clinicians, and the sufferers themselves misunderstanding the symptoms and the reality of major depressive disorder, an increasing global health problem. This autobiographical case report reflects on twenty years of treatment-resistant depression and a journey through pharmacological approaches, psychotherapy treatment, Christian prayer counselling, and electro convulsive therapy without improvement in this condition. The primary concern is how to remain faithful and effective with this condition in a service-oriented occupation that requires regular emotional expenditure. In lieu of effective conventional and non-conventional therapies, the remaining option is to find a way to manage chronic depression; identify personal trends, weaknesses, and triggers; and find a personalized way to live that minimizes the effects of the condition. In any chronic, incurable disorder, the sufferer must inevitably come to terms with his or her reality and find peace in the acceptance of that reality. By expressing the journey through treatment-resistant depression, the author encourages readers to persevere in ministry and to respond more appropriately to the afflicted with clearer understanding and empathy. A companion article on mitigating depression symptoms through the spiritual discipline of identifying with Christ and His experience of human emotional pain during His passion is available.

Key words: Treatment Resistant Depression, Suffering, Missionary retention, Empathy, Transcendence

Introduction

According to a World Health Organization estimate, unipolar depression is the leading cause of ill health and disability worldwide, affecting 300 million people.[1] Worldwide, irrespective of cultures, there has been a steady increase in the reported cases of depression, considered an epidemic of modernization. There has been some association

with global increases in obesity, poor diet, sleep deprivation, sedentariness, social inequality, and social isolation, but a specific cause of the increase has not been determined.[2] The increased incidence has particularly affected younger age groups in diverse global contexts. Loss of family stability, increases in individualism, reduced religious observance, and industrial environmental factors have been implicated.[3]

Trivedi and Greer conclude that although anti-depressant treatment may offer some improvement, symptoms can also persist residually for the life span.[4] Though there is no universally accepted definition, treatment-resistant depression (TRD) is commonly defined as no response to two or more antidepressant trials of adequate dose and duration.[5] Al-Harbi identifies that depressive illness-related factors, personal characteristics, medication variables, and psychosocial stresses collectively contribute to the development of TRD and are associated with a considerable disease burden. He notes that 10-30% of cases of depression are refractory to pharmacologic treatment, and 30% of those with TRD do not respond to any treatment.[6]

Gish identified 19 stressors that contributed to a possible build up to depression among cross-cultural workers that, if unrelieved, lead to health issues, relational problems, and cognitive impairment.[7] A study in the United States concluded that 35% of pastors battle depression, fear, and anxiety, and that only one out of ten pastors will retire as a pastor.[8] Depression is a major cause of attrition among cross-cultural workers, with an incidence of 27-32% among missionary healthcare workers.[9]

Burnout does not equate with depression but is often a precursor to depression if left unmanaged. Hodges posits that the remedy for ministerial burnout may be found partially in transcendence of purpose combined with intrinsic values and community. The transcendence of which she speaks does not mean the eradication of all symptoms, but it allows the sufferer the ability to function and contribute while minimizing the constant negative influences and subconscious suggestions of depression through a faith focusing on the positive aspects of God and His promises.[10]

There is little in the literature on the nexus between persistent ministerial depression, cross-cultural stress, and missionary retention. My contribution is an autobiographical case report from which I hope to offer an understanding of the depths of misery of one suffering this affliction and a way of approaching transcendence for ministerial endurance. Depression is a visceral, irrational, and stupefying state that may persist despite sincere efforts of the faith community, member care of faith-based organizations, and psychotherapeutic approaches by professional mental health practitioners. Depression, even if treatment resistant in nature, does not need to be a disqualifying condition for effective cross-cultural or ministerial service, but can be redeemed by perseverance and endured through faith and a consistently-dependent relationship with God. Charles Spurgeon, Hudson Taylor, William Carey, and Saint Teresa of Calcutta are all good examples of this, but contemporary examples and analysis are needed.

Experience with Treatment-resistant Depression

As a cross-cultural missionary to southern Philippines for the past 30 years, I have experienced significant treatment-resistant depression, a disease of the brain, and if you will allow, the soul. It is an affliction, disability, “personal demon” (figurative), a form of insanity, profound and inexplicable sadness, debilitating listlessness, white-hot electric anxiety (symptoms which can accompany depression), near-complete emotional disassociation, debilitating fear, irrational guilt, untethered moral and spiritual confusion, and unabating assaults on self-worth and all things good. My contribution to the problem is a more visceral and intuitive understanding of the experience of

depression, and how, despite its persistence, it has been managed by the grace of God through faith and spiritual disciplines. Solutions without empathetic personal understanding often are not effective treatment options for mental illness conditions where people are in need of emotional connection.

Family and Phyco-social History

There is a long family history of depression and brokenness in my family. I was raised in the United States. Shortly after my birth, in the early 1960s, my mother had what she called a nervous breakdown, which included hallucinations of demons crawling on the walls. Unfortunately, she never recovered and never admitted she had a problem and, therefore, was never diagnosed or treated. She would regularly and for no apparent reason go into fits of violent rage at the speed of flicking a light switch. She would often beat me until she got tired or hurt herself, whichever came first. When I got older, bigger, and stronger, she resorted to weapons. But worse than this was the relentless emotionally emasculating ways she verbally destroyed every ounce of self-esteem I would ever have. This rage was expressed physically and verbally until I was old enough to leave home. My father never talked about being a virtual orphan during his up-bringing, but he made it clear to us that two of the most clearly understood rules as I was growing up were, "no complaining," and "no excuses." He was a quiet man until he lost his temper. I remember him giving me advice only twice in my life. He was not prone to compliments or affirmation.

Personal Transformation

When I found faith and embraced Jesus with all my heart at the age of twenty, in 1982, I was bursting with unadulterated joy and zeal. I felt a compelling desire to serve as a missionary among the poor overseas. I began my career when I was twenty-two. For years I had felt a spiritual energy that helped me push through insurmountable obstacles and helped me accomplish more solid missionary goals in my first few years of cross-cultural work than one could reasonably expect after a lifetime of service. I felt unstoppable in my faith. I worked hard, slept little, and grew accustomed to working in life-threatening environments in relief and development projects in impoverished conflict zones. My biggest fear was not kidnapping, bullets or bombs, but rather, not measuring up to other people's expectations. Much of my early ministry was probably motivated by the need to prove my worth.

About thirteen or fourteen years into my missionary career, I started to feel different. By this time, my amazing wife and partner in ministry had borne me four beautiful daughters, I had founded a mission, published a book, earned the respect of most of my peers, and had significantly invested in the lives of thousands. We lived simply, without much money, but we were content. Since we were not a member of a recognized mission organization, we were often painfully rejected by our peers who were members of larger organizations. Essentially, we were isolated with small children in a war zone for ten years.

Affective Decline

The first signs were subtle and confusing. I remember during a break at one of my missionary training courses in 1999, I was in my room and feeling completely devastated. People from all over the country had traveled to our remote location to be trained by me, but I, irrationally, felt like a complete failure and fraud. It took every fiber of will to force myself to walk back to the classroom and teach. Something had changed. I am no stranger to spiritual warfare, but I honestly was not able to understand what weaknesses were being exploited by spiritual powers and what weaknesses were the results of overwork or possibly biological imbalance. I did not know what I was experiencing, but it was about to get worse. The successive years led to our team planting the first church among a previously

unreached tribe in 2003. I had reached my goal of building our local organization up to national sustainability and was in the process of passing the leadership of the mission over to my protégés. At this stage, I still was unaware that I was trying to regain my sense of self-worth through my accomplishments and working harder than everyone else.

At the pinnacle of missionary success, I felt indescribably miserable. It was baffling. I had doubts of my legitimacy. I had doubts about my accomplishments. I had doubts about some aspects of my faith. I began to long for an existence untethered to spiritual obligation. I felt brutalized by irrational guilt and daily assaults of neurotic self-loathing. My confusion was extreme, and I began to lose my connection to all things dear. I wanted to escape, but I had no idea of where to escape. Burnout? Maybe. For a couple of years I had brushed off the possibility of depression because I thought it was the invention of lazy people who wanted to justify their weaknesses. "No complaining. No excuses," was the way I was raised as a child, and I carried that attitude into adulthood; so I did not see the need to seek help.

The years progressed, and life got lower, darker, more confusing, and more hopeless. I remember the first time my mind wandered off to a fantasy state sometime around 2007, where the thought of not being alive was so much more appealing than being alive in my condition. By this time, I had already passed leadership of our mission over to my Filipino protégé and had taken my family to the United States to experience my side of their cultural heritage. I realized that it was the first time I had consciously thought of suicide as a possible answer to the deep pain I constantly felt.

Two years before that, in 2005, we were hit with hurricane Katrina and our house, as well as most of the Mississippi Gulf coast, experienced catastrophic damages. The floods rose so fast that I had to swim out of a bedroom window with my two youngest children on my back amidst debris and 200 kph winds. By this time, I had started a fledgling construction company to support my family. The work demands were high, and the days were long. I began to slip deeper and deeper into a level of stress overload for which I had no vocabulary. Then, while we still did not have internet, phone, electricity, or water, my Filipino mission leader protégé died from a brain tumor at age 38. I was not aware that he had passed for nearly two weeks, which was misinterpreted by some of my staff that I did not care. It took me more than two years to unburden myself from debts and commitments in the United States, raise support, and move back to the Philippines to rebuild my life's work.

My sense of responsibility to people for whom I had moral obligations was all that was keeping me in the ministry. In 2009, I moved my family back to the Philippines. Joy was often a distant concept after the initial sense of "coming home" to my calling had receded. My visits to the province and my recruiting and training of new staff became a heavier and heavier burden for me. It is not possible to describe the black, oppressive weight that crushed the life out of me twenty-four hours each day. Thoughts like the non-existence of God were intruding into my mind and managed to stay around regardless of how hard I tried to drive them out. All the mornings were hard. Though I had insomnia, sleep was the closest thing to oblivion and the only time I was not in constant, savage agony.

Diagnostic and Treatment Approaches

A diagnosis of major depressive disorder was suggested, in 2002, by a retired American psychologist I consulted first through email while in the Philippines and then in person while visiting the United States, but only psychological tests and an assessment were offered. In 2004, I returned to the United States for five years, and in 2006, I tried to explain to my American family doctor about the white-hot panic and fear, the dark oppression that eclipsed all positive emotions, and the intense,

constant misery I felt. I showed him the uncontrollable trembling in my hands. He listened but did not seem to take my complaints seriously, nor accept the previous diagnosis of depression until I told him about some anti-depression medication commercials that I had seen. After that, he basically gave me what medications I asked for. If I revisited him weeks later with more depression symptom complaints, he would take me off the medicine I was currently on, without tapering, and prescribe another. In 2007, I sought help from a psychologist who confirmed the diagnosis of major depressive disorder and began a very cursory form of psychotherapy. I also consulted a psychiatry professor at a major university who seemed extremely qualified, but he was an hour's drive away in another state, because I did not want anyone in my small town to see me walking into a psychiatrist's office. He hardly ever made eye-contact during our ten-minute monthly sessions in 2007-2008, as he focused on writing prescriptions of different kinds at each visit, often filling my arms with free sample packs. This did not provide any relief. Upon my return to the Philippines in 2009, and in 2011, I consulted a Filipino psychiatrist who made a better effort, and I spent six months with him in weekly Freudian psychoanalysis while continuing adjustments in anti-depressant medications. At the end of this time, he diagnosed treatment-resistant depression, basically admitting that there was nothing more he could do for me, but would prescribe any available medication of which I had researched and for which I asked.

Over the period from 2006 to 2017, I was prescribed at least nine different anti-depressant medications starting with fluoxetine followed by extended trials of venlafaxine and duloxetine in addition to tranquilizers, anti-psychotics like quetiapine, anti-anxiety medications like clonazepam, and sleep aid sedative-hypnotics like zolpidem. None seemed to make any difference in my depression but produced uncomfortable side-effects, like tremors, numbness or tingling sensations, listlessness, cognitive impairment, sexual dysfunction, incoordination, and feeling like a zombie. Ultimately, the prescription of different medications was a well-intentioned, but unsuccessful, search for something that could provide relief.

My teeth chattered uncontrollably for several years. I learned to mask it well in public. I could not experience enjoyment of food, sex, family, money, hobbies, adventure, faith, or fellowship. I was not just numb. I felt like I had lost my soul and was walking around without it. Sometimes changing medicine was not well supervised by my doctors, and I would go into full-blown withdrawals that included convulsions, hallucinations, insomnia, vomiting, fainting, and incoherence. Due to little guidance, I had to learn by trial and error how to taper off medicines. There was no collaboration between doctors. None of my doctors were available by phone, so geographical distance often made the treatment sporadic. During my time in the United States from 2004 to 2009, I still had work and church responsibilities that required me to literally drag myself out of the house and engage with the world seven days a week. I had a mortgage, a construction company, clients, and six mouths to feed. My wife was very compassionate, but scared during this time, and things were generally good with the children. I was determined not to drag anyone else down with me, so I pressed on.

After fourteen years of various medications, different forms of psychotherapy, and Christian counselling, my condition became so severe in 2016 that I sought out what I considered extreme therapy and requested six bi-lateral electroconvulsive therapy (ECT) sessions in January 2017. During my convulsions, I fractured a molar and tore my rectus abdominus muscle so severely that it took me seven months to be able to sit up without significant difficulty. After the treatment, I suffered confusing side effects and spent the next two months in bed. There were significant gaps in my memory that still remain empty. For nearly two months, full body spasms came without warning about a dozen times a

day, and new tactile, verbal, and auditory hallucinations were common, tremors were constant, and incoherence came and went. This lasted a few months. After this disappointing attempt at a cure, I experienced a deep slide back into my depression which eventually eroded hope that I could ever be cured.

Adaption to My Current Condition

My depression symptoms persist to this day. I have come to accept my condition while neither surrendering to it nor being completely disabled by it. In a way, my weakness forces me to look to God in faith because my sight is so diminished. I have lost the ability to enjoy legitimate pleasures, but somehow, after so long, I still hope that this capacity will someday, in some form, be restored. In the meantime, I have found ways to live a productive life and remain in my cross-cultural service context as I realistically manage my capacity by operating within my known limits. For example, I know that most social interactions bring me to a critical breaking point after two and a half hours. I know that I will usually have four significantly productive days in a week. One or two days I often crash completely and do not get much of anything done, like a forced Sabbath rest. And usually I have one neutral day where I am able to function at a basic survival level doing chores, errands, etc. I have learned to coordinate my schedule according to my limits and to identify the feelings that indicate the need for rest and withdrawal which suggest an imminent crash.

Though it seems divergent to the victorious life in Christ I am supposed to experience, I often feel like a cold, lifeless being that tries to project normalcy for the benefit of others. I do not pretend to understand this seeming contradiction except perhaps that it forces me to look to God more intentionally and more frequently. Fortunately, my feelings do not define my relationship with God. Most of what remains of my ability to feel is the capacity to experience the negative emotions of guilt, perceived rejection, self-loathing, fear, and loss. Without this pain, I would have little sensation at all, and I have to daily remind myself of the promises of God that contradict my negative emotions. This, and my intentional recognition and thanksgiving for the good God has allowed in my life, even when I can not feel it, daily constitute a form of cognitive behavioral therapy for me. Many saints before me have gone through longer and more difficult trials that have almost certainly resulted in depressive periods. Our conventional concept of joy has to do with things like happiness, fulfilment, exuberance, prosperity, lack of problems, and good health. Is it possible to find a different, more subtle, and possibly even a deeper form of joy without these qualities through a settled faith and surrender to God in the midst of our uncomfortable situations?

Attempts at Integration

The soul is sometimes defined as a combination of one's mind, will, and emotions. In my case it seems that there is a disintegrating, and at times, contradictory relationship between these three components. It feels like I have mostly my mind to get me through this life for now. My will is feeble and anemic at times, and my heart, my passion, which used to be the strength that defined my personality, has all but faded away. Yet despite this disintegration, there is the occasional synapsis between the three. These occasions remind me that there is hope for recovery... someday.

Outwardly, I look normal. No one would guess that I almost always feel like a hollow man without a normal, free-functioning soul—a Frankenstein's monster, an outcast, a misfit, an invalid—breathing, walking, and speaking in a weary, middle-aged body. Most of the time, the darkness within me is stronger than the light, but occasionally I get a glimpse of the sun, and my hope is renewed that God is with me, watching me, remembering me. It was not until I was in my mid-20s, after talking with peers about their childhoods, that I began to realize that my

childhood was not normal or nurturing. There are many who fall into this category. My mind tells me that the Bible is true, that God is real, and that He loves me. My heart feels almost nothing emotionally supportive of this most of the time. Duty has eclipsed delight.

The Complexity of Etiology

The cause of my condition remains elusive. Perhaps my insecurity-driven motivation to prove myself has contributed to my condition, or perhaps it has been my abusive childhood, genetic pre-disposition, independent-mindedness, or the stresses of cross-cultural service. I am not a legalist, but I have been an individualist most of my life, which may have led to isolation. My pursuit of care and treatment were not optimal, due to limited resources, travel schedules, and no collaboration between mental health providers. My independent-mindedness isolated me from potentially healing contexts. Long-term misery had a negative impact on important relationships that would otherwise have been supportive among family and ministry colleagues. Each time I come back "home," I find that time, distance, and other interests and seasons of life have reduced the closeness with friends that used to bring me such encouragement. Sometimes, I regret the single-hearted devotion with which I have served as a missionary for thirty plus years. When one focuses almost exclusively on one's calling, it is unbalanced and, in the end, fails the ideals of the body of Christ which values people more than productivity. The loss of intimacy and comradery is one of the things I hope to have restored.

The Necessity of Transcendence

I have managed to remain relevant by a conscious and consistent focus on Jesus and His presence with me by faith despite the inability to feel connected to Him. The Bible describes faith as, "... being sure of what we hope for and certain of what we cannot see." (Heb 11:1 [NIV]). Faith is what tethers us to a God we cannot see when all our senses tell us He is not there. In the end, when all other reasonable options have failed for the sufferer of depression, this case report and my companion article *Biblical reflection on the passion of Jesus Christ as it relates to 20 years of treatment-resistant depression*[11] suggests that faith can help those who suffer TRD transcend the debilitating symptoms of depression and provide the hope necessary to remain productive, seek healthy relationships, and contribute to society and transformational development.

Conclusion

With the global burden of disease from depression increasing, the limitations in access to good mental health services, and as many as 30% of depressed persons not being able to fully recover from their illness regardless of responsible treatment, the global medical, psychological, and religious community is faced with a significant challenge. Empathy, understanding, perseverance, and patience seem to be a key to effective support for depressed persons. Building global capacity for better availability, collaboration, and competency of mental health services is vital. Reducing isolation through systems of caring and supportive relationships within family, organization, and community is critical. Faith is essential for hope, and hope is essential to cope with the heavy darkness of treatment-resistant depression. For those who follow the Christian faith, remembering that Christ is not aloof and far away, but has experienced our humanity and pain and lives in us by His Spirit helps us to connect with Him in a unique way when we are in emotional pain and seeking to connect and minister to others (2 Cor 1:4). An intentional focus on the example, promises, and the presence of Christ in our life combined with our assurance of complete relief after this body is fully transformed might be the most effective approach by which to transcend

the debilitating symptoms of major depression disorder and continue to persevere in effective ministry to others.

References

1. World Health Organization [Internet]. Depression: let's talk. 2017 April 7. Available from: https://www.who.int/mental_health/management/depression/en/
2. Hidaka BH. Depression as a disease of modernity: explanations for increasing prevalence. J Affect Disord. 2012;140(3):205-14. https://doi.org/10.1016/j.jad.2011.12.036
3. Goleman D. A rising cost of modernity: depression. New York Times. 1992 Dec 8. Available from: https://www.nytimes.com/1992/12/08/science/a-rising-cost-of-modernity-depression.html
4. Trivedi MH, Greer TL. Cognitive dysfunction in unipolar depression: implications for treatment. J Affect Disord. 2014 Jan;152-154:19-27. https://doi.org/10.1016/j.jad.2013.09.012
5. Trevino K, McClintock SM, McDonald Fischer N, Vora A, Husain MM. Defining treatment-resistant depression: a comprehensive review of the literature. Ann Clin Psych. 2014 Aug;26(3):222-32. Available from: https://www.ncbi.nlm.nih.gov/pubmed/25166485
6. Al-Harbi KS. Treatment-resistant depression: therapeutic trends, challenges, and future directions. Patient Prefer Adher. 2012 May;6:369-88. https://doi.org/10.2147/PPA.S29716
7. Gish DJ. Sources of missionary stress. J Psychol Theol. 1983;11(3):231-6. https://doi.org/10.1177/009164718301100309
8. Strand MA, Pinkston LM, Chen AI, Richardson JW. Mental health of cross-cultural healthcare missionaries. J Psychol Theol. 2015 Dec 1;43(4):283-93. https://doi.org/10.1177/009164711504300406
9. Pastoral Care Inc [Internet]. Statistics in the ministry. Statistics provided by The Fuller Institute, George Barna, Lifeway, Schaeffer Institute of Leadership Development, and Pastoral Care Inc. [cited 2019 Feb 15]. Available from: https://www.pastoralcareinc.com/statistics/
10. Hodges S. Mental health, depression, and dimensions of spirituality and religion. J Adult Dev. 2002 April;9(2):109-15. https://doi.org/10.1023/A:1015733329006
11. York H. Biblical reflection on the passion of Jesus Christ as it relates to 20 years of treatment resistant depression. Christ J Global Health. 2019;6(1):51-58. https://doi.org/10.15566/cjgh.v6i1.279

Peer Reviewed: Submitted 27 Jan, revised 1 April, accepted 13 April, published 31 May 2019

Competing Interests: None declared.

Correspondence: Hunter York, Philippines. hunteryork68@yahoo.com. Note that for reasons of patient privacy and security, a pseudonym was used for the author.

Cite this article as: Hunter York. Understanding treatment-resistant depression: A missionary's autobiographical case report. Christ J Global Health. May 2019; 6(1):43-50. https://doi.org/10.15566/cjgh.v6i1.275