

LEA

Monograph

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Burnout, Depression, & the Professional Church Worker

By Ronald L. Rehrer



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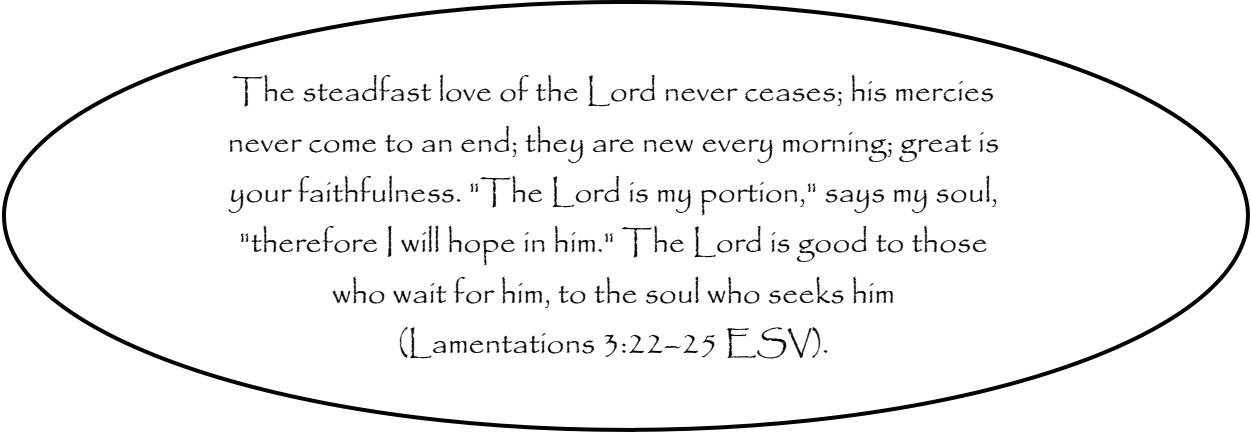
Foreword

Burnout and depression never get old nor are they anything new. We read about them in Old Testament days. Working for God in a church work profession doesn't provide an exemption. In fact, the devil might especially enjoy playing with the emotions of those who have dedicated themselves to working in the name of Jesus.

Burnout and depression among church workers have long been a concern of LEA. That's why, in 1991, LEA commissioned Rev. Ronald Rehrer to write "If Life is Peaks and Valleys, Why Do I Always Feel Down in the Valley? Depression and the Professional Church Worker." What you are about to read is a revised and updated version of that publication. A special thank-you goes to Rev. Rehrer, M.A., MFC, for his willingness to undertake this task. His current ministry includes the Healthy Workers/Healthy Leaders Ministry of the Pacific Southwest District, LCMS.

Burnout and depression may be personal. They may affect your family or colleagues. Therefore, this *LEA Monograph* treats its reading audience as potential victims and also potential helpers. I pray God's strength for you and that this resource will assist and inform you in your ministry.

Edward Grube



The steadfast love of the Lord never ceases; his mercies never come to an end; they are new every morning; great is your faithfulness. "The Lord is my portion," says my soul, "therefore I will hope in him." The Lord is good to those who wait for him, to the soul who seeks him
(Lamentations 3:22-25 ESV).

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Please note: This monograph is not a comprehensive treatise on the subject of burnout and depression. It is intended to provide initial information for LEA members who are concerned about their own emotional health or the emotional health of a colleague or family members.

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Burnout

When church workers are exposed to too many stresses over a sufficient length of time, this can lead to burnout. Burnout can be the first step toward more serious emotional disturbances.

Many church workers do not give themselves enough recovery time and do not know how to take good care of themselves emotionally, physically, and spiritually when under great stress. Examples are when workers refuse to take a day off or when workers believe they are not allowed to get sick, except when getting ill fits into a day off or vacation time!

Several difficulties need to be overcome if church workers are to avoid burnout:

1. Church workers need special training on how to handle conflicted situations and difficult personalities in the ministry (most workers had no such training in college or seminary). A good place to begin would be to read *Antagonists in the Church* by Kenneth C. Haugk (see Additional Resources at the end of this monograph).
2. Church workers often are in a continual state of alertness, and the work is never done. That is why it is critical that workers take off at least one day (completely away!) each week, and take at least three or four weeks of vacation each year.
3. Regardless of the type of ministry, workers discover that often there is a lack of criteria for measuring work accomplishment. It is difficult to measure success, and the “bottom line” (numbers and dollars) is usually how church workers feel others evaluate them (i.e., by how many youth are in the youth group, how many events have taken place, etc.). Again, it is important that workers find value and meaning simply in doing the work and not in how others do the evaluation. If evaluations will be in numbers and dollars, then the worker might consider working with future evaluators in realistic expectations of ministry.
4. Church workers often are placed upon pedestals and have difficulty with their own humanness. They fear the loss of face, self-respect, and respect of others, including the threat of loss of prestige, power, and control should they fail to live up to the expectations of others. Workers need “safe places” to reveal their human frailties and problems, so that these do not interfere with their work. If they do make mistakes in ministry and are confronted on them, it is best to remain as non-anxious as possible, admit the error, seek forgiveness and reconciliation (remembering that not all people actually want reconciliation!), and then accept their imperfections. Everyone makes mistakes.

Additional ways of preventing stress and burnout are:

1. Setting realistic boundaries and limits on what can be done in a day, a week, a month.
2. Exercise at least three times per week, preferably daily: Walking is sometimes the best!
3. Eat well-balanced meals, limit “junk food,” reduce alcohol intake, and avoid “eating on the run.”
4. Get sufficient sleep. Some people function best on eight or nine hours of sleep, while some function best on just five. Whatever the natural body rhythm, it should not be abused by staying up too late or by working 16-hour days. Give mind and body sufficient recovery time.
5. Set aside time to spiritually refresh through prayer and reading of Scripture, etc. God’s power regenerates us far beyond imagination.
6. Learn relaxation techniques that seem natural and comfortable. Do them in times of stress or tension or after a stressful event or set of circumstances.

7. Find or create a support group where you can talk freely without being evaluated or criticized. This may be outside your place of ministry and can be invaluable for mental and spiritual well-being.
8. Find a mentor or select someone you respect and trust to advise you or give you suggestions or feedback for times when you are feeling insecure, inadequate, insufficiently trained, overwhelmed, etc.

Depression

No one is immune to depression, not even professional church workers. Experts say that depression hits every family.

Depression is so pervasive throughout society that it has been called the “common cold” of mental illness. Understandably, most of us don’t go to a doctor for the common cold. We attempt to deal with it ourselves, treating it by drinking lots of fluids, trying to get more rest, taking cough medicine, and consuming anti-congestion medications. Only when the symptoms worsen do most of us go to a doctor. We don’t see *having a cold* as a sign of weakness in our character. We know better. Colds happen to almost everyone. That’s why they are called *common*.

Depression is *common* in the same way. Nearly everyone gets depressed once in awhile. As with the common cold, most of us try to deal with depression by ourselves. Some people find brisk exercise (jogging or swimming, for example) to be an excellent home remedy to help lift a depression. Others have found that talking to a trusted friend and turning to God in prayer also helps them feel better. There are many ways people can treat a depression themselves. But some forms of depression aren’t so easily treated, and sometimes it is important to see a doctor when the symptoms recur.

We sometimes speak of colds in different ways. We try to put into words the level or intensity of the discomfort. So we sometimes say, “I have a *slight* cold,” or “I think my cold is *getting worse*,” or “I have a *terrible* cold,” and each description speaks of the person’s cold in slightly different ways.

In a similar way, it is possible to experience depressions in various degrees. Some might say, “Oh, I just feel a little down,” or “I don’t seem able to manage things very well,” or “I’m so depressed.” Sometimes the intensity can become so great that words cannot describe the intensity of emotional discomfort.

Most church workers feel depressed sometimes. It isn’t unusual to feel down, defeated, overwhelmed or helpless. It isn’t unusual to not know what’s causing their depression. Even healthy, vibrant church workers feel this way. It is not a sign of character flaws. It is not a sign of lack of faith. The Psalms have many images of being downcast and defeated, and many were written by a man of great faith, David.

Luther, at various times, struggled with bouts of depression. Many of today’s best known preachers and church leaders will tell you of the times when they have also struggled with depression and doubt, often feeling overwhelmed, defeated, sad, lonely, unappreciated, ignored, isolated, even to the point of feeling like “throwing in the towel.” We can’t always tell how a person really feels on the inside when we only see them in their public ministry. More church workers than we might imagine feel exactly how we sometimes feel on the inside, but like us, they don’t often tell anyone about it.

It is appropriate to see a doctor when feeling depressed. In fact, it can be a very real mistake not to visit a family physician or a counselor for an evaluation or assessment. For example, some organic, chemical, or biological factors may be causing the depression, or something overlooked in a life

situation may be contributing to a depression; without a professional opinion, depression might indeed worsen. Why not see someone to explore what might be happening? Why continue to suffer when there is good professional treatment available?

Physicians and mental health specialists are trained to take descriptions of feelings and put them into standardized categories used for understanding the intensity and severity of depression. Accordingly, depression is categorized as *mild*, *moderate*, or *severe*.

A mild depression can last a few minutes, a few hours, or a few days. Like the common cold, it just seems to run its course. But a moderate depression can last a few weeks or a few months, and it doesn't just run its course like the common cold. And severe depressions can last for a few months and sometimes for years, bringing with them debilitating pain and suffering. The impact on the afflicted, their families, and their co-workers can be devastating. Their experience really is like a deep, dark valley from which there seems no return and no hope of escape.

What is depression?

In everyday language, when someone says that he or she is feeling *depressed*, it is not always easy to know what that person means. Some people use the term to indicate that they feel *blue* or *low*, *sad* or *down* or *disappointed* or *fatigued*. Different people mean different things when they say they are depressed. Or they may use other words to indicate the condition we know as depression.

Depression means a slowing down of the normal functions of body, mind, and emotions. Physically a person may walk slower, often talk slower, have difficulty getting out of bed in the morning, or feel as if they are in a slump all day long. Mentally, a person may have difficulty paying attention, find their mind wandering, or be unable to focus. They may not think as clearly nor respond as quickly to questions. Emotionally, they may feel sad, lonely, or defeated. There is a loss of joy or pleasure in life, and they may dislike themselves or others.

How intensely the depression is felt or for how long depends greatly on a person's prior life experiences, beliefs, coping skills, family support system, network of friends, willingness to share feelings, and other variables. How a person perceives life's events, losses, changes, transitions, etc. may strongly influence the course of any depression. The ability to find hope and meaning also is crucial to the outcome of any depression.

Depression is a serious matter because it affects many aspects of a person's life, including the quality of one's life, health, and spiritual life. Longer lasting depressions, for example, not only interfere with normal day-to-day activities and functioning, but they can negatively affect the body's immune system, making it less able to ward off certain types of illness, placing the person at higher risk for certain types of health problems.

In addition to altering our body functions, depression can also affect how we feel, what we think, and even what we believe. Depressed people, for example, may lose their appetite, have difficulty sleeping, and feel lousy, while thinking to themselves, "I'm really no good," "I'm not suited for the ministry," or "I'm always going to be a failure." Sometimes they think to themselves, "If people really knew what I was like, they wouldn't like me or follow my leadership." Emotionally, they may feel a deep sadness, despair, emptiness, and emotional pain. Spiritually, they may say to themselves, "God doesn't love me anymore." Additional variations include: "If there really were a God, this wouldn't be happening to me," "Why me, Lord?" or "What did I do to deserve this?"

Depression impacts emotional, physical, intellectual, and spiritual well-being in powerful ways. Here are some common symptoms:

Emotional	Physical	Intellectual	Spiritual
Sadness	Loss of energy	Mental confusion	Feeling abandoned by God
Indifference	Fatigue	Self-blame	Feeling punished by God
Loss of pleasure	Sleep disturbance	Depreciation of self	Doubting own faith
Despair	Loss of appetite	Irrational thoughts	Diminished devotion and prayer life
Feeling “down”	Continuous eating	Catastrophic thinking	Anger at God
Apathy	Rapid weight gain/loss	Low self-worth	
Easily hurt	Decreased sexual interest		
Difficulty handling anger	Panic & anxiety attacks		
Easily frustrated	Restlessness		
On the verge of tears	Hyperactivity		
Desire to blame self	Headaches		
Self-reproach	Backaches		
Self-blame	Stomach pains		
Sense of inadequacy	Constipation		
Low self-esteem	Dizziness		
Negative thinking	Short term memory loss		
Mood swings increase	Preoccupation with body functions		
Worry	Poor concentration		

Reactive Depression

The following cases illustrate real examples of depression among church workers but are disguised to protect identities.

Case Studies

Let’s take a look now at how various types of depression specifically affect church workers.

Case 1

A DCE is terminated without warning because of budget cutbacks. She’s done nothing wrong. Without

job security, she and her young family face immediate financial crisis. She feels angry, sad, and helpless. This has been a terrible blow to her self-esteem and self-worth. She feels guilty ("If only I'd done MORE, maybe they wouldn't have fired me.") She feels depressed and unsupported by her church. She wonders why she chose a church work career in the first place.

Case 2

A Lutheran school teacher and his wife have been struggling in their marriage. He has recently moved out of their home into a small apartment nearby and has begun to drink more heavily. His wife finds herself gaining weight and having difficulty getting up in the morning. At night she sits staring blankly at the television set, with tears slowly rolling down her cheeks. Both feel defeated, sad, and hopeless.

Case 3

A young, eager pastor accepts the challenge of revitalizing a declining congregation after several years of successful pastoring. But, after many long hours and hard work using new evangelism strategies "guaranteed to work," only a handful of new prospective members come to worship. Members of his floundering congregation feel devastated, while the young minister becomes depressed and despondent. In his heart, he believes that the failure is his fault. He feels inadequate, discouraged, and unprepared for this defeat. He wonders what his fellow pastors and District officials will now think about him. Unable to sleep at night and not wanting to eat, he finds himself weeping at unexpected times and for no apparent reason, while his wife and children are no consolation to him.

Each of the above cases illustrates one particular type of depression known as *reactive depression*. Reactive depression is caused by a trigger event or set of circumstances, which is perceived by the person as a very great loss. The person's perception of the loss is more important than what has actually happened. It is how one sees the loss that greatly determines the reaction. Earlier losses may contribute to an even more severe depression.

Dr. Archibald Hart, noted Christian psychologist, says "All reactive depression is, in some way, a response to loss." The loss can be experienced as a shameful kind of event or as a deprivation of something considered crucial to one's identity. The loss can be the loss of prestige or power. It can also be loss of control, which makes one feel helpless. The loss may also feel like being stripped of one's worthiness or one's purpose in life.

Since *loss* is the key factor in reactive depressions, this form of depression is a type of grieving. These felt losses need to be grieved just the same way as one would grieve the loss of a loved one because of death. In our society, there are rituals such as funerals, graveside ceremonies, meals with family and friends, etc., to assist grieving people in the loss of a loved one.

But when one suffers losses in the ministry (loss of face, loss of control, etc.), there are few resources to help grieve these losses. In addition, most church workers hide these feelings and try to look as if nothing is bothering them. They think to themselves, "I should be able to handle this on my own!" This often exacerbates the reactive depression when it comes; that is why a depressed worker should seek professional help from a competent Christian counselor who can help him grieve and sort out thoughts, feelings, perceptions, and beliefs about the "loss" before the depression worsens or ministry performance suffers. A good counselor is trained to help acknowledge these losses, express hurt and anger, end denial, and find new ways of relating to the world.

Sadly, some church workers are reluctant to seek help. They think, "I am the helper, and the helper doesn't need help!" They say, "I am called and ordained (or commissioned), and that means I am above

needing help!” Some writers call this the Jesus Syndrome or the Savior Complex, believing that the helper is above any help. They ignore the early signs of depression. They try to perform outwardly as if nothing is wrong, even when they feel emotionally distant from others. They put on an outward smile. But they are like a broken Thermos®: The outside looks fine, but inside, the glass is shattered, and they clink, clank, and clunk within, where no one can see their hurt, pain, and depression.

Their ministries often suffer because they refuse the help to mend their broken spirit and heal their inward wound. They often minimize their losses, which often leads to greater loss of vitality and joy. Their losses can also result in deeply felt shame. When this happens, workers can become very driven in their work. Inward shame drives them towards perfectionism and overwork. But they are never happy or content because they cannot run away from the deep loss inside.

With any loss there are actually several losses: the *primary loss* and all the *secondary losses*. For example, if a woman’s husband dies, the loss of her husband is the primary loss. But she doesn’t lose only her husband, she also loses all of the other relationships she has had with him.

Similarly, when a professional church worker loses a job or experiences separation or divorce, or fails at a ministry, not only is there a primary loss, but there are many other secondary relationship losses. All of these need to be grieved in order to achieve the best possible recovery.

Other types of depression

While we briefly discussed the reactive type above, depression can also be a symptom, such as a side effect from a prescription medication, a reaction to an illness or medical condition, or a physical response to hormonal changes.

Depression can also be a *disease*, such as when patients are diagnosed with a psychotic depression. Persons with this condition have something organically wrong with their brain and/or body chemistry, which creates the depression. While depression can be seen as a reaction, symptom, or disease, the following types of depression are commonly observed by mental health workers and physicians. These include:

- Endogenous depression (meaning *from within* the body). While not fully understood, it is believed that body chemistry has been altered by earlier, prolonged stress causing continuous states of depression. Anti-depressant medication, reduction of stress loads, exercise, adequate sleep, and good diet form the basis of treatment.
- Neurotic depression (an old term). This is a habitual depression often used to avoid responsibilities and sometimes to escape from unwanted experiences. While the patient can use this as a means of manipulation, it often has a long history and is deeply embedded within the person, therefore necessitating a professionally trained therapist with good skills for treatment.
- Psychotic depression. This is a severe depression, with severe symptoms (extreme hopelessness, a sense of gloom and doom, no energy, withdrawal from almost all normal activities, with a perceptible neglect of personal hygiene, appearance, health issues, inability to go to work, etc. Very strong feelings of guilt, remorse, sinfulness, impossibility of forgiveness, self reproach, and paranoia are common. Unusual sensations and feelings and even hallucinations and delusions are sometimes present.
- Bipolar or manic-depression. So called because the patient fluctuates between the two poles of depression and elation over days, weeks, or months. The manic phase is often characterized by

obsessive thoughts and behavior (e.g., spending and gambling sprees, and other narcissistic compulsions).

- Unipolar. Only involving depression and is best treated with antidepressant medication
- Dysthymia. A milder form of depression common among church workers. It is based on unresolved issues from childhood, which impact current moods, thought, and performance.
- Cyclothymia. A milder and quite normal fluctuation in mood, created by the biological rhythms of the body.
- Seasonal Affective Disorder (S.A.D.) A condition most often brought about by the lack of sunlight during long winter months when the weather is gloomy, overcast, and gray.

Suicide: When the pain is so great...

Sometimes church workers get so deep in the “valley of despair” that they see absolutely no hope. They become more despondent and have death fantasies and suicidal thoughts. Some even begin to make plans for ending their lives.

Psalm 22:1–2 puts into words the deepest of these feelings: “My God, my God, why have you forsaken me? Why are you so far from saving me, from the words of my groaning? O my God, I cry by day, but you do not answer, and by night, but I find no rest” (ESV).

The psalmist poignantly describes the experience of those most deeply depressed...the sense of being forsaken and of finding no help. There is the deep groaning within and the cry, which seems to go unheard. There comes no answer to one’s plea and one can find no rest.

The book of Job also speaks of deep grief. Consider the following passages:

“Then Job answered and said: ‘Oh that my vexation were weighed, and all my calamity laid in the balances!’” (Job 6:1–2 ESV).

“If I speak, my pain is not assuaged, and if I forbear, how much of it leaves me? Surely now God has worn me out; he has made desolate all my company” (Job 16:6–7 ESV).

When these thoughts and feelings are too intense and there is no light at the end of the dark tunnel, a person can turn to suicide as a final solution to ending the pain and suffering.

Suicidal thoughts are extremely common in depression. While most people who think about suicide never commit suicide, these suicidal thoughts and ideas must always be taken seriously. Professional help and hospitalization should always be considered for those suffering such deep hopelessness and pessimistic futures.

Following a suicide attempt, and during what appears to be a successful time of recovery, the risk increases for another suicide attempt, if there is a setback. The reason for this is that once the person begins recovering and feeling better and stronger, that person has more energy with which to attempt suicide. It is important for family, friends, and colleagues to remain supportive during the entire phase of recovery and not to abandon the person who looks and feels better. In the normal course of depression, setbacks always occur.

Hope

In my position as a counselor to professional church workers, I have seen dozens of church workers and members of their families who have felt depressed, defeated, and alone. They feel deep in the valley, lost, and confused. But with professional help and treatment, along with the support of family, friends, colleagues, and church leaders, these workers have felt the fog of depression lift and their heavy hearts lighten. In fact, they have found what so many others suffering from depression have found...hope! They learned that depression is treatable and can be beaten. They learned that there is real help available.

This is good news. The depressed are no longer alone, nor do they need to suffer alone. God is with them as they learn to trust Him as He leads them into trusting others to help and care for them, giving them hope and new insight into the nature of their depression.

By placing trust in God and physicians and caregivers, we can learn what so many others have learned: that while life has peaks and valleys, we do not have to stay trapped down in the valley!

Treatment for depression: ways out of the valley

Church workers are especially prone to depression because the nature of church work is often discouraging, with far too many tasks to be done in too little time with too little help, too few resources, and too little appreciation. Church workers are highly vulnerable to criticism when events do not go as planned. Church workers often feel discouraged when there are setbacks and disappointments in achieving goals. They often suffer from faulty thinking. They blame themselves when something goes wrong instead of being realistic about the fact that despite their best efforts things can go wrong.

Church worker family members are also prone to depression, since they often try to live up to others' expectations within the school or congregation, only to discover that they can never get it right. This is known as "living in the fishbowl" in which the church worker's family are the fish being watched from the outside by church members, parents, or even other staff. Workers become anxious about what others will say about them, and this often is followed by depression (and anger) when they hear someone really has a negative opinion about them (e.g., They don't like the way the worker's children behave or dress or they think the worker's family is too involved or too uninvolved in the church, etc.). This can lead to co-dependency, where the worker's sense of well being and good feelings are bound to what others think and feel towards them.

Add to this the possibilities of controversy within the congregation, school staff conflicts, financial problems, family conflicts at home, illness, mid-life crises, career reassessments, aging parents, etc. In addition, spouses of workers often feel lonely and isolated, with too few friends and too many hours spent alone. It is easy to see why church workers (and their spouses!) can get depressed. But help is available.

The following licensed and/or certified professionals treat depression:

- Licensed physicians and psychiatrists. Most primary care physicians know about anti-depressant medications, their usefulness, and possible side effects. But it is best to be treated by psychiatrists (an M.D. with license to practice psychiatry) because they specialize in anti-depressant medications. Certainly a Christian psychiatrist would be most helpful, but they are not the only trustworthy doctors.
- Licensed clinical psychologists. These therapists have a Ph.D. and are usually not licensed to dispense medications. They have specialized training in testing, evaluation, and psychotherapy.

- Licensed Marriage, Family, Child Counselors. These therapists specialize in understanding relationships and how systems impact people in negative ways, leading to depression. They work with individuals, couples, and families, and can assess/diagnose and treat depressions. They are state licensed to work with the public.
- Licensed Clinical Social Workers. These are social workers who have expertise in a wide range of clinical issues facing individuals and their families, and many are Christians as well.
- Pastoral Counselors. These are pastors with specialized training in mental health and family life care, often endorsed by their respective denominations, with a theological perspective and earned theological degree.

The American Association of Pastoral Counselors (AAPC) has a Web site where you can find a pastoral counselor.

Health insurance often covers counseling on an outpatient and inpatient basis. Examine the provisions of your coverage, especially when you are feeling healthy.

Psychiatrists and other M.D.s can prescribe anti-depressant and other medications. It is important to remember that most anti-depressant medications are described by the manufacturers of those meds as being non-addictive. Be sure you ask about this issue and about any other side effects. Also ask about potential side effects when taking the prescribed antidepressant with any other medications. Most anti-depressant drugs take several weeks to reach optimal effect because it takes that long for them to build in your system. Again, ask your medical doctor about how long it will be before the medications begin to have a positive effect.

Doctors will also request periodic check-ins, so they can adequately monitor responses to the medications.

Medication

Medication comes in a variety of forms aimed at differing conditions. Over the past 15 years there has been a great advance in medications available for treating depression (as well as other mood disorders, thought disorders, delusions, schizophrenia, and other mental health disorders). Most medications for depression are designed to affect one or more of the three chemicals in the brain known as neurotransmitters. These three chemicals are known as serotonin, dopamine, and epinephrine. Some of the medications that treat these chemicals in the brain are known as SSRIs (Selective Serotonin Reuptake Inhibitors), which seek to boost the serotonin levels in the brain so that there is a better, more improved mood. Physicians will discuss the various options and their rationale for recommending a certain medication.

Physical Treatment

Hospitalization

When one's coping resources are nearly exhausted and depression is overwhelming, hospitalization can be extremely useful in interrupting the depression. The support of the nursing staff, daily psychotherapy, group work, and regulation of proper medication, plus the "break" from relationships and work stressors on the outside, can be a welcome relief and the beginning of recovery.

When suicidal thoughts or suicidal threats are uncovered, then hospitalization should be seriously considered. When suicide seems imminent, it is critical that a 9-1-1 phone call be made to get the suicidal person to safety and into hospitalization.

Psychotherapy

The term means literally *treatment of the mind*. There are many different types of psychotherapy, but the ones listed here are among the most effective with depression.

- **Cognitive Therapy.** A drug-free treatment for depression, researched at the University of Pennsylvania School of Medicine and made popular by Drs. Aaron T. Beck and David Burns, (see the *Feeling Good* books in the Additional Resources at the end of this monograph) This approach teaches patients to discover and change automatic negative thoughts, which perpetuate depression. Dysfunctional thoughts and behaviors are challenged and advantages for changing these are explained and reinforced.
- **Client-Centered and Insight-Oriented Therapy.** Depressed people often feel isolated, alienated, and alone, so that a close, supportive relationship with a therapist is extremely useful in helping a person regain some balance. During these exploratory sessions, past life events and recurring patterns of behavior, which contribute to the depression, are uncovered. Unfulfilled needs are addressed, which leads to exploring new options and possibilities for getting these met.
- **Behavior Therapy.** Most depressed persons slow down and stop normal activities. Behavior therapy is designed to reactivate them. Activities are prescribed. There is assertiveness training to overcome the common problem of “earned helplessness” and systematic desensitization training to reduce fear and anxiety in the face of difficult situations.

How to choose a therapist: some guidelines

Talk with your pastor, family doctor, friends or trusted colleagues to get the names of two or three therapists in your area. Someone who is well recommended is always a good starting place. I usually recommend a competent, sensitive, licensed Christian therapist. If one is not available, then choose a competent, sensitive, licensed, non-Christian therapist (see Additional Resources below for additional help in finding a therapist).

Call the therapist’s office and find out if he or she treats depression and has special training in this area. While all therapists have experience working with patients who are depressed, not all may be trained in treating depression. So be sure to ask if the counselor is competent to treat depression.

Decide for yourself if you feel the therapist understands you, and if you feel that there is hope for you by seeking this form of treatment for your condition (or condition of your loved one, friend, or colleague). If you answer *yes* to both of these considerations, then it is very likely that you will form a good working relationship with the therapist.

Remember that it will take time and that there are no instant cures.

Conclusion

Many avenues and resources are available for treatment, healing, and recovery for those suffering burnout and depression. God has provided resources such as medications, psychotherapy, hospitals, physicians, pastoral counselors, marriage-family-child counselors, social workers, friends, colleagues, our families, and Himself for support. No one should suffer for a long time from depression. It is crucial that we help those suffering find the right resources, both internal and external, so that life and joy and freedom are experienced once again.

Additional Resources

1. *You Can Beat Depression: A Guide To Prevention & Recovery*, Fourth Edition (Paperback). John Preston, Psy. D. Impact Books.
2. *Feeling Good: The New Mood Therapy Revised and Updated* (Mass Market Paperback). David D. Burns, M.D. Signet.
3. *Mind Over Mood: Change How You Feel by Changing the Way You Think*. Dennis Greenberger and Christine Padesky. The Guilford Press.
4. *Helping Someone with Mental Illness: A Compassionate Guide for Family, Friends, and Caregivers* (Paperback). Rosalynn Carter and Susan M. Golant, M.A. Three Rivers Press.
5. *Coping with Depression in the Ministry and Other Helping Professions*. Archibald D. Hart, Ph.D. Word Publishers.
6. *Antagonists in the Church: How to Identify and Deal With Destructive Conflict*. Kenneth C. Haugk. Augsburg Publishers
7. *Depression Hits Every Family*. Grace H. Ketterman. Thomas Nelson, Inc.
8. *How To Go On Living When Someone You Love Dies*. Therese A. Rando. Bantam Publishers.
9. *How to Survive the Loss of a Love* (Mass Market Paperback). Peter McWilliams, Harold H. Bloomfield, Melba Colgrove. Prelude Press
10. *How Your Church Family Works: Understanding Congregations As Emotional Systems*. Peter L. Steinke. Alban Institute

Help in finding a counselor

You may also wish to try the following Web sites for help in finding a counselor or learning more about a particular therapy:

- AAPC, the American Association of Pastoral Counselors at <http://www.aapc.org/>
- AACC, the American Association of Christian Counselors at <http://www.aacc.net/>
- AAMFT, the American Association for Marriage and Family Therapy at <http://www.aamft.org/>
- CAMFT, the California Association of Marriage and Family Therapists at <http://www.camft.org/>
- Clinical Psychology: http://en.wikipedia.org/wiki/Clinical_psychology
- Psychiatry: <http://en.wikipedia.org/wiki/Psychiatry>

For further help finding a Christian counselor

You may call your District for the names of qualified pastoral counselors or Christian counselors. Many Districts have Ministerial Health Committees or someone designated for Worker Health who are ready to assist you in finding the right resource. You may also call your local organization of Lutheran Social Services or Lutheran Family Services, since many of these agencies either have counselors on their staff or have referral resources for them.

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