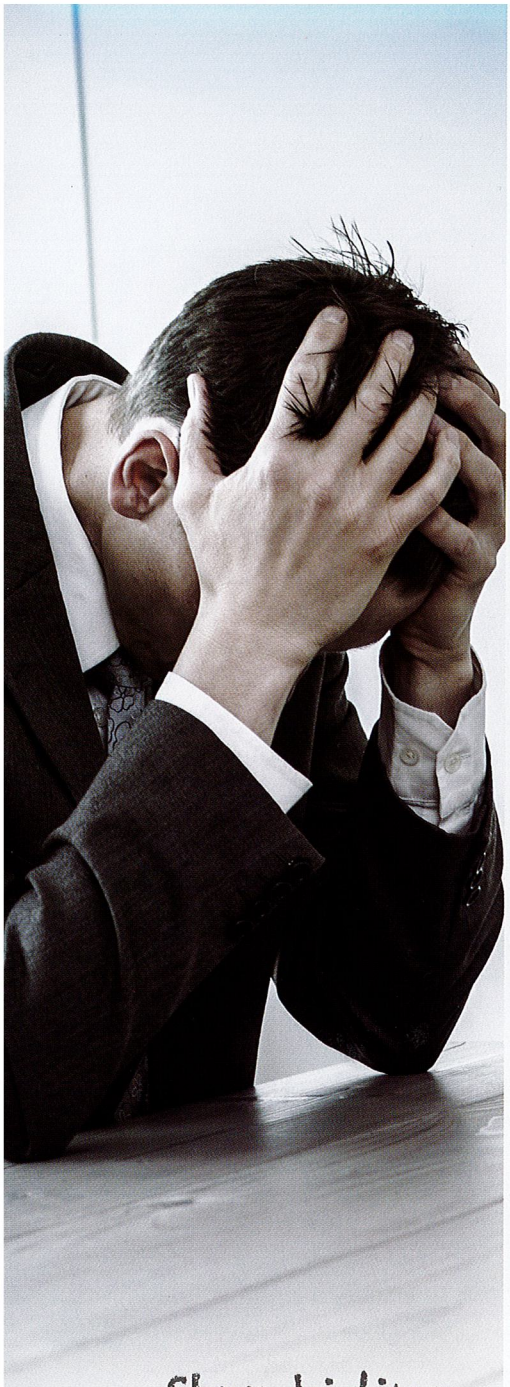


# DEPRESSION and PASTORS

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He was perhaps the preeminent evangelist of his era. He had interacted with political and religious leaders with integrity; even those of other faiths recognized his impact. His walk with God and effectiveness in ministry was never called into question—even when he faced significant challenges. His prayers were answered in ways deemed miraculous both then and now. But he struggled with depression. He had trouble eating, sleeping and connecting with others. Burdened by a loss of energy and motivation to press on, he left ministry. He abandoned relationships. His mood was low; he believed that his days of making a significant contribution, of having any value to God or His people, had come to an end. He was hopeless. He wanted to die.

This story doesn't come from my clinical files. It comes from the 19th chapter of 1 Kings. The evangelist described above was Elijah. And he is not alone.

After Nineveh was spared, Jonah stated "It is better for me to die than to live" (Jonah 4:8). Jeremiah mourned "cursed be the day when I was born" (Jeremiah 20:14). Many of the Psalms recount the emotional struggles of King David. From more recent history, we have stories of Abraham Lincoln and Winston Churchill, penultimate leaders who struggled through significant bouts of depression when they questioned their abilities, their effectiveness—even their will to live.

## WHAT IS DEPRESSION?

Depression is a term that has been around for a long time; it has been back in the news in recent weeks—but it is still largely misunderstood as to what it is and what should be done about it.

In an effort to establish standardized care, the American Psychiatric Association established diagnostic criteria for a "major depressive episode." A major depressive episode is characterized by a cluster of at least 5 of 9 symptoms. These symptoms include depressed mood ("most of the day, nearly every day"), diminished interest in activities, significant changes in weight, significant changes in sleep patterns, psychomotor agitation, loss of energy, feelings of worthlessness, diminished ability to concentrate, and recurrent thoughts of death. These symptoms (at least 5 of them) need to be present for at least 2 weeks. Once three such separate episodes occur, the individual meets criteria for "major depressive disorder."

While some—including conservative Christians—have criticized this system of "labeling," the purpose of establishing specific criteria is so that we can identify what works to help those with that specific collection of symptoms so that we can more accurately provide services to others.

Some, under the guise of being sensitive to the complicated nature of emotional distress and those who are afflicted, have referred to depression as a disease. This is an inaccurate way of looking at depression—in fact, an inaccurate way of looking at most mental disorders.

The term that best fits is in fact the one most often used by mental health professionals: disorder. Such a term acknowledges that there is something out of the ordinary without inappropriately implying what isn't entirely known to us. For while there are physical symptoms consistent with depression, that doesn't mean that depression can be reduced to a biological disease.

Rather than viewing depression solely through the lens of a medical model, mental health professionals use what is called the biopsychosocial model. This framework is a more holistic way of looking at all behavioral and emotional distress.

Yes, biology is a key domain. The physical chemistry of the brain and inherited genetic coding should be acknowledged as contributing to the predisposition toward symptoms of depression. But predisposition is not causation. While modern psychiatric medications can be prescribed to help alleviate some of the symptoms of depression, there are other factors necessary to "trigger" depression.

The second domain is psychological. In this category, we include an individual's personality, temperament, self-esteem, stress management and coping skills. These characteristics often relate to an individual's upbringing and previous experiences—both nurturing as well as traumatic. Counseling can help individuals to understand how these impact their behavior and emotions and how to identify and strengthen appropriate coping strategies.

The third domain is social. As individuals created in the image of a relational Triune Godhead, we are created for relationships. Interactions with family, friends, and colleagues all work to build us up (or tear us down). The most current literature includes spirituality in this category. Intervention in this domain focuses on helping to strengthen relationships and social interactions as well as building faith and connection to God and His people.

Comparing depression to diseases like cancer or diabetes does a disservice to those afflicted with those diseases—and to those who need intervention for depression as well. Depression cannot be reduced to a simple lack of faith, nor can it be reduced to what some refer to as "chemical imbalance."

## PASTORS

The US Department of Health and Human Services, through the National Institute of Mental Health, estimates that 6.7% of US adults experience symptoms of depression that warrant intervention. A recent report issued by the Clergy Heath Initiative noted even higher rates in pastors. A high-profile Christian neuroscientist recently proposed that one out of every four pastors struggles with depression.

The research that I conducted at the Interchurch Holiness Convention in 2011 indicated that pastors who identify themselves as part of the Conservative Holiness Movement were able to assess depression in others with accuracy. They indicated a willingness to refer those in their congregation with depression to mental health professionals. However, when it came to pastors' willingness to seek intervention themselves, the numbers indicated some additional hesitation.

While there's no shame in acknowledging a physical disease, because of the complex nature of depression and other mental health disorders, there remains a stigma about seeking intervention from a mental health professional. Sometimes medical treatment will be sought for the specific physical symptoms but then other contributing factors are overlooked.

Pastors—like Elijah—are in high-profile, high-stress positions. Many consider themselves "always on call" to the congregants they serve. Due to financial pressures, a number of pastors are required to engage in secondary employment in order to make ends meet. Depressive thoughts may lead to guilt over not being able to live up to the high standards they've set for themselves.

What can we learn from the account of Elijah's depression? That running and hiding doesn't work. Elijah was physically afflicted. Physical exhaustion often leads to discouragement and irritability. Proper rest, diet, and exercise are protective factors against depression and can help to alleviate some symptoms. Neglecting your calling and isolation from others only makes the problem worse. Not only did God provide for Elijah's physical needs, He got Elijah active in the ministry again—and provided him with a companion in Elisha.

Intervention for depression has a high success rate. Those who address each of these three domains—biological, psychological, and social—have a 90% success rate according to one recent study.

If the story of Elijah resonates with you, seek help. Stop over-working. Take care of your physical body. Foster relationships within your family. Reconnect with friends and fellow pastors for edifying and encouraging support and accountability. Find a credentialed Christian counselor in your area. Talk to your primary care physician.

Stop hiding. Stop pretending that you can push through on your own.

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