

THE INTERSECTION OF  
MINISTRY AND MENTAL HEALTH:  
WORSHIP LEADERS WITH DEPRESSION

By

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## ABSTRACT

Despite the fact the mental health issues are becoming more destigmatized among those in society, pastors and other church staff still face unique challenges when seeking treatment for mental health issues. This study considers the perspectives of ministers who often struggle in silence with depression. This qualitative historical research study will identify the unique challenges faced when battling depression that have not yet been studied concerning the lives of worship leaders in various stages of such mental health issues. Time demands, financial challenges, and stigma have emerged as common themes through exploration of a small body of existing literature and personal narratives of participants who serve as worship leaders. To illustrate the experiences of these men and women, an examination of current research and personal accounts of worship leaders who suffer from depression will be conducted in order to offer guidance for not only those suffering from these mental health issues, but for their families and congregations as well. This work is needed because the stigma associated with these challenges force many worship leaders to silently suffer through their battles with depression. The study of worship leaders with depression is just now being explored by researchers. This project will examine the intersection of ministry and mental health issues. Further, this study could encourage further research by others in the areas of ministry burnout, Christian counseling, and the use of psychotropic medications by those in ministry positions.

*Key words:* anxiety, depression, worship leadership

## LIST OF ABBREVIATIONS

Acceptance and Commitment Therapy – ACT

Cognitive Behavioral Therapy – CBT

Christian Emotion Focused Therapy – CEFT

Diagnostic and Statistical Manual – DSM

Emotion Focused Therapy – EFT

Mindfulness-based Cognitive Therapy – MBCT

Maslach Burnout Inventory – MBI

Major Depressive Disorder – MDD

Mindfulness-Based Stress Reduction – MBSR

Religious Cognitive Behavioral Therapy – RCBT

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## CHAPTER ONE: INTRODUCTION

The Creator God, in His infinite wisdom, gave His children the ability to experience a wide range of feelings and emotions. Throughout the course of just one day, it is not uncommon for one to experience feelings of joy, happiness, fear, anger, anxiety, and sadness, just to name a few. This range of emotion is what allows humans to freely choose to express worship back to the Heavenly Father. Although it was in God's perfect plan to allow His children to experience these emotions, after the fall of man as accounted in the book of Genesis, these same feelings, thoughts, and emotions began to be manipulated by Satan in order to steal, kill, and destroy the beauty of God's creation and create distance and confusion among God's children. Genesis 3 lists several thinking traps that humans were allowed to experience after the fall: shame (v. 7), isolation (v. 8), fear (v. 10), deception, (v. 11), blame (v. 12), lies (v. 13), and challenges in one's daily walk (v. 18).

Documented examples of depression can be found in biblical accounts of Moses, Elijah, David, and Job. Luke 22:44 notes an account of Jesus suffering from hematohidrosis, which is a rare condition of sweating blood, due to the anguish of knowing that He would be crucified the following day. In more recent times, well-known Christians such as Mother Theresa, Charles Spurgeon, and Martin Luther suffered their own *dark nights of the soul*, yet despite such accounts, there is still negative stigma associated with Christians who suffer from anxiety and depression.<sup>1</sup>

According to research conducted by LaPierre and others, pastors who experience depression are often considered to have such struggles as the result of a "lack of faith."<sup>2</sup> This can

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<sup>1</sup> Aaron Loy, "Confessions of a Depressed Pastor," *Relevant Magazine*, August 28, 2018.

<sup>2</sup> Lawrence LaPierre, "Coping with Anxiety," *Circuit Rider*, May 1, 2010, <https://www.ministrymatters.com/all/entry/431/coping-with-anxiety>.

create a sense of pressure for those in ministry to either hide their symptoms, or refuse to seek professional treatment. This perceived pressure on pastors to not openly share their struggles with mental health conditions may be why studies find that depression rates among clergy are often greater than hypothesized.<sup>3</sup>

Although there are many similarities in the responsibilities and perceptions of worship leaders and pastors, there are additional challenges for worship leaders who suffer from depression. Historically, Levites led Old Testament armies into battle, but openly sharing depression and anxiety to the rest of the army would likely not calm the fears of the army before a battle. Similarly, worship leaders are expected to lead the congregation, often made up of individuals facing their own personal battles, to victory, but this can be much more difficult when the leader is facing similar battles that may cause the worship leader to appear to have a lack of faith. Addressing the stigma of worship leaders with depression may foster an environment conducive to finding a balance between ministry and mental health.

### **PROBLEM STATEMENT**

Although many worship leaders have a desire to lead their congregation in worship with joy and authenticity each week, struggles with depression may actually inhibit that from happening effectively.<sup>4</sup> While one may find substantial research regarding pastors who struggle with depression, there is limited research on worship leaders who struggle with depression. If these issues are not addressed, it could lead to compounded frustration on the part of the worship

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<sup>3</sup> Lisa Unger, "Depression Rates and Help-Seeking Behavior of Baptist Ministers" (PhD diss., Walden University, 2011), in ProQuest, <http://search.proquest.com/docview/861920178>.

<sup>4</sup> Noel Due and Kirsten Due, "Courage and Comfort for Pastors in Need," *Lutheran Theological Journal* 52, no. 3 (December 2018): 128-40.

leader, and confusion in the hearts of the congregation as they observe concerning behaviors of the worship leader not only when he or she is on the platform, but in the hearts of fellow worship team members in rehearsals.

Waves of depression in the worship leader may lead to a greater sense of needing to hide depressive symptoms from the congregation in order to appear strong enough to lead them through their struggles. This incongruence could also lead to more intensified symptomology. Thoughts of fear and failure could make the worship leader less receptive to feedback from the pastor or members of the governing body of the church. The need for affirmation could cause the worship leader to focus more on perfectionism by getting caught up in a cycle of *all or nothing* thinking. Regarding such thinking, Griggs notes, “All or nothing thinking forms the basis for perfectionism. It causes you to fear any mistake or imperfection because you will then see yourself as a complete loser, and you will feel inadequate and worthless.”<sup>5</sup>

Despite the fact that worship leaders are staff members of the church, they too are members of the flock and need to be shepherded by the Pastor. Blanton and Morris note, “Many pastors are not trained to identify the symptoms of depression and anxiety, which will limit his or her ability to provide needed support.”<sup>6</sup> As more pastors become aware of the prevalence of depression, as well as the need for treatment, they will likely share that information with the congregation to demystify the stigma associated with mental health issues.

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<sup>5</sup> Robert W. Griggs, *A Pelican in the Wilderness: Depression, Psalms, Ministry, and Movies* (Eugene, Oregon: Cascade Books, 2014), 44.

<sup>6</sup> Priscilla W. Blanton and M. Lane Morris, “Work-Related Predictors of Physical Symptomatology and Emotional Well-Being among Clergy and Spouses,” *Review of Religious Research* 40, no. 4 (jun. 1999): 331-48, <https://www.jstor.org/stable/3512120>.

## STATEMENT OF PURPOSE

The purpose of this study is to identify both the etiology and symptomology of depression as well as propose effective forms of support and interventions for the depressed worship leader according to current literature regarding worship leaders with depression.

Although many worship leaders have a desire to lead their congregation in worship with joy and authenticity each week, struggles with depression may actually inhibit their ability to do so effectively.<sup>7</sup> While one may find substantial research regarding pastors who struggle with depression, there is diminutive research on worship leaders who struggle with depression. This study will address the specific needs of worship leaders with depression as well as the residual effects that those around the worship leader may experience. Additionally, effective intervention strategies will be offered to provide fellow church staff members with resources to minister to the specific needs of a worship leader struggling with depression.

## SIGNIFICANCE OF THE STUDY

A study on worship leaders with depression is necessary because those impacted could include hundreds or thousands of people including the worship leader, family members, members of the worship team, members of the congregation, and fellow staff members.

Worship leaders who struggle with depression may have a skewed interpretation of theology as Brian Johnson notes, “Often in the midst of great loss, people will reduce their theology to match their experience.”<sup>8</sup> This reduction in theology could affect the way that he or she personally prepares for, and leads worship services. Additionally, the worship leader may

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<sup>7</sup> Noel Due and Kirsten Due, “Courage and Comfort for Pastors in Need,” *Lutheran Theological Journal* 52, no. 3 (December 2018): 128-40.

<sup>8</sup> Brian Johnson, *When God Becomes Real* (Redding: Bethel Book Publishing, 2019), 70.

inadvertently select songs that reflect a skewed theology, all of which would have an impact on not only the worship leader's private worship, but corporate worship as well.

This study is significant to the families of worship leaders who struggle with depression because they are likely to see more of the symptomology at home as the worship leader may feel pressure to present with a more positive affect than what they actually feel internally. Family members are likely to see the greatest presentation of symptoms, as Lovejoy notes, "Unattended wounds festering deep under the surface inevitably wear down the brave façade of peace and reassurance believed necessary for a minister who wishes to portray the mind of God."<sup>9</sup> As a secondary consequence, the worship leader's children may develop a skewed perception of God as they see their parents exhibiting vastly different behaviors at home and on the platform.

This study is significant to members of the worship team who may have noticed increased irritability of the worship leader while working through rehearsals. The once jovial worship leader may soon become isolated and create distance between himself and the rest of his team.<sup>10</sup> The worship leader may also find that he or she is not as able to effectively shepherd the worship team who has likely noticed the changes, but did not know the reason.

This study is most significant to the worship leader who may have lost a sense of hope that the symptoms of depression can be reduced. Becoming aware of the prevalence of depression among other worship leaders may reduce feelings of isolation. Additionally, the interventions examined could lead to a restored sense of hope of a life free of depression or at least at a manageable level of symptomology.

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<sup>9</sup> Gary H. Lovejoy, *A Pastor's Guide for the Shadow of Depression* (Indianapolis, Indiana: Wesleyan Publishing House, 2014), 27.

<sup>10</sup> Johnson, *When God Becomes Real*.

## **STATEMENT OF PRIMARY RESEARCH QUESTIONS**

Research questions concerning the challenges of worship leaders with depression should address those issues that are pertinent to symptomology, etiology, and effective intervention strategies.

The research questions for this study were:

Research Question 1: What are the unique challenges faced by the worship leader when struggling with depression?

Research Question 2: In what ways can the church staff support the needs of the worship leader when struggling with depression?

The first research question is significant because the challenges that are faced by worship leaders are not only unique from congregants who do not hold ministry positions, but there are also unique challenges that differentiate the struggles of a worship pastor from those in other ministry positions within the church. The second research question is significant because church staff members need to know how to recognize the symptoms of depression in order to shepherd their fellow staff members. The need for worship leaders to be shepherded when struggling with depression is supported by Charlotte Witvliet who notes, “Religious strain such as feeling abandoned by God and by one’s congregation during difficult times, increases stress and psychological vulnerability.”<sup>11</sup> A qualitative historical approach was utilized in an attempt to provide insight on why some worship leaders struggle with depression.

## **CORE CONCEPTS**

In order to have a clear understanding of this study, an understanding of a few key concepts should first be established. First, a brief explanation of the diagnostic criteria that will

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<sup>11</sup> Charlotte vanOyen Witvliet, “Speaking Well in Worship about Mental Illnesses: A Beginner's Guide to Language and Resources,” *Reformed Worship*, June 2018.

be used as well as differentiating feelings of sadness from a clinical diagnosis of depression. Additionally, etiological considerations such as the physiology as well as spiritual warfare should be differentiated.

Mental health clinicians utilize the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) to diagnose mental health conditions. The DSM-5 is the most current edition. According to the DSM-5, in order to meet criteria for a clinical level of depression, five or more of the following criteria must be met for a consistent two-week period: depressed mood most of the day almost every day, diminished interest in all activities most of the day, weight change, insomnia or hypersomnia, psychomotor retardation or agitation most of the day, fatigue, feelings of worthlessness, indecisiveness, or recurring thoughts of death.<sup>12</sup> It is important to note that not all feelings of sadness meet diagnostic criteria for Major Depressive Disorder. Sadness is a natural emotion, but sadness and depression are not the same thing. When the previously listed symptoms begin to interfere with one's activities of daily living it may be time to seek professional help.

When offering help to someone with symptoms of depression, it is a good idea to rule out any physiological issues that may cause the presenting symptoms. Mental health clinicians often require their clients to obtain a physical to rule out thyroid, blood pressure, or glucose issues, which can be a source for symptoms of depression.

When considering a mental health disorder such as depression, one must consider the possibility that the symptoms present are actually the result of spiritual warfare. Many forms of spiritual attack mimic symptoms of mental health disorders. One must evaluate the source of the

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<sup>12</sup> Diagnostic and Statistical Manual of Mental Disorders: **DSM-5**. Arlington, VA: American Psychiatric Association, 2013.

symptomology and treat accordingly. Although medication may alleviate the symptoms of some spiritual issues, it does not actually treat the underlying cause. Similarly, the Lord can deliver someone from their symptoms of depression, or He may choose to walk through this dark season of life with them as they seek medical interventions.

### **Hypothesis**

The hypotheses that answered the research questions are as follows:

Hypothesis 1: The challenges unique to worship leaders struggling with depression include: incongruence, doubt, and spiritual warfare.

Incongruence occurs when the internal self is significantly different from the external, or public self that is often presented to others. Many worship leaders feel a sense of pressure to present a positive public appearance as Gary Lovejoy notes, “Unattended wounds festering deep under the surface inevitably wear down the brave façade of peace and reassurance believed necessary for a minister who wishes to portray the mind of God.”<sup>13</sup> Noel and Kirsten Due similarly note, “On the one hand, mental resilience and psychological stability are often regarded as essential character traits (both by pastors and parishioners), but on the other many factors inherent in pastoral ministry mitigate against them. This often leads to a clash of expectations (both internal and external) which can manifest in either acute crises and/or chronic depression.”<sup>14</sup>

Worship leaders struggling with depression may have doubt regarding God’s love for them, His ability to help them, and His sovereignty, just to name a few. In sharing his struggle with depression, Matt Rogers notes, “I began to think I was seeing the world as it was, when in

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<sup>13</sup> Gary H. Lovejoy, *A Pastor's Guide for the Shadow of Depression*. 27.

<sup>14</sup> Noel Due and Kirsten Due, “Courage and Comfort for Pastors in Need,” *Lutheran Theological Journal* 52, no. 3 (December 2018): 128.



fact everything was dimmed by the darkened lenses through which I viewed all of life.”<sup>15</sup> The presence of doubt may interfere with the worship leader’s ability to lead with authenticity.

Finally, worship leaders struggling with depression may face spiritual warfare. One of Satan’s main goals is to stop people from authentically worshipping God. One form of attack is to prevent the worship leader from effectively leading others in worship by various forms of spiritual attack. Worship leader Brian Johnson faced various forms of spiritual attack at an early age and notes, “Over the years, through my dad’s teaching, I’ve come to understand the four weapons he used to fight the attacks of the enemy – the name of Jesus, the blood of Jesus, the Word of God, and worship.”<sup>16</sup>

Hypothesis 2: The church staff can support the needs of worship leaders struggling with depression in terms of: awareness of symptoms, therapeutic interventions, and burnout prevention.

Church staff members cannot help a worship leader with depression if they are not aware of the symptomology of depression. It is not necessary for staff members to be diagnosticians, but an increased awareness of mood and behavioral changes would likely prove beneficial. Lisa Unger encourages collaboration between clinicians and church staff as one possible option noting, “The counseling community must become engaged with this population and help ministers understand the mental health diagnosis of depression, acknowledge how depression

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<sup>15</sup> Matt Rogers, *Losing God: Clinging to Faith through Doubt and Depression* (Downers Grove, Ill.: IVP Books, 2008), 118.

<sup>16</sup> Johnson, *When God Becomes Real*, 41.

impacts personal and professional abilities as well as identify effective sources of mental health support for this population.”<sup>17</sup>

Additionally, church staff members can offer help through awareness of effective therapeutic interventions. Research conducted by Walz and Bleuer found, “group counseling appears to be the best avenue for helping a large number of clergy family concerns.”<sup>18</sup> Similarly, Alydia Smith suggests the use of Resiliency Training noting, “Resiliency has to do with a person’s ability to deal with adversity and stress in constructive and undamaging ways. It is a testament to how well someone is able to adapt and function (bounce back) when confronted by internal and external stressors.”<sup>19</sup>

Finally, specific training on the causes of burnout and burnout prevention may prove beneficial to church staff members as they attempt to help a worship leader with depression. Regarding the prevalence of burnout, Smith notes, “We need ministers who are burning-up with passion and enthusiasm for worship and the work of the church, yet somehow this need is creating ministers who too quickly lose their passion and even more who ‘burnout’ while trying to meet these great expectations.”<sup>20</sup> Church staff members who are trained to identify the symptoms of burnout are a great help to worship leaders struggling in this area.

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<sup>17</sup> Lisa Unger, “Depression Rates and Help-Seeking Behavior of Baptist Ministers” (PhD diss., Walden University, 2011), in ProQuest, <http://search.proquest.com/docview/861920178>.

<sup>18</sup> Garry R. Walz and Jeanna C. Bleuer, “Clergy Families: The Helpless Forgotten’s Cry for Help Answered Through Reality Therapy,” *Vistas Online* (2013), [https://www.counseling.org/docs/default-source/vistas/clergy-families-the-helpless-forgottens-cry-for-help.pdf?sfvrsn=1c17cd2b\\_11](https://www.counseling.org/docs/default-source/vistas/clergy-families-the-helpless-forgottens-cry-for-help.pdf?sfvrsn=1c17cd2b_11).

<sup>19</sup> Alydia Rae F. Smith, “Keeping the Fire Burning (Without Getting Burnt): Helping Worship Leaders Maintain Their Passion for Ministry through Resiliency Training” (DMin diss., Drew University, 2015), in ProQuest, <http://search.proquest.com/docview/1678629410>.

<sup>20</sup> Ibid.

## RESEARCH METHODS

According to Creswell, the qualitative design was appropriate for this study because characteristics of Pastors with depression were examined to identify common themes in the literature.<sup>21</sup> Further, a historical approach was appropriate for this study because the current literature collected was used to make predictions about the efficacy of future interventions. For this study, a qualitative method was utilized by evaluating existing literature regarding the diagnostic criteria for depression, interventions for treating pastors with depression and methods of support for the worship leader with depression. A historical approach was utilized by taking the information collected and used to make predictions about the efficacy of future interventions.<sup>22</sup>

### Definition of Terms

The following terms are defined to help the reader understand the context of each term in this study.

*Anxiety*: a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome.<sup>23</sup>

*Depression*: feelings of severe despondency and dejection.<sup>24</sup>

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<sup>21</sup> John W. Creswell and J David Creswell, *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, fifth ed. (Los Angeles: SAGE, 2018), 13.

<sup>22</sup> Edward Hallett Carr, *What is History*, (New York, NY: Random House Inc., 1961), 35.

<sup>23</sup> *Oxford Dictionaries*, s.v. “anxiety,” accessed August 10, 2019, [//www.oxforddictionaries.com/definition/english/anxiety](http://www.oxforddictionaries.com/definition/english/anxiety).

<sup>24</sup> *Oxford Dictionaries*, s.v. “depression,” accessed August 10, 2019, [//www.oxforddictionaries.com/definition/english/depression](http://www.oxforddictionaries.com/definition/english/depression).

*Incongruence*: as defined by Carl Rogers, a lack of alignment between the real self and the ideal self.<sup>25</sup>

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<sup>25</sup> American Psychological Association, “incongruence,” accessed August 10, 2019, <https://dictionary.apa.org/incongruence>

## **CHAPTER TWO: REVIEW OF THE LITERATURE**

### **Introduction**

This chapter reviews literature which pertains to various issues related to worship leaders with depression. The literature review consists of eight sections. First, literature is reviewed which includes personal accounts from pastors and worship leaders who suffer from depression. This will provide a first-hand account of the struggles associated with depression among those in ministry. The second section presents a review of the literature pertaining to the diagnostic criteria for depression. In this section, clinical criteria for depression will be differentiated from feelings and emotions that do not interfere with daily activities and which do not meet diagnostic criteria. This section will also include research on similarities between depression and forms of spiritual warfare. The third section of this literature review will examine the role of clergy in mental health treatment. Similarly, the fourth section will consider denominational differences in regards to mental health treatment. The fifth section of the literature review will examine treatment options for those who suffer from depression. Within section five, a closer examination will be offered for effective treatment options for those in ministry as well as conflicts that may arise between secular and Christian intervention strategies. The sixth section will examine literature pertaining to stigma associated with pastors with depression as well as other reasons why those in ministry often do not disclose mental health conditions to others. Section seven will consider the stigma that often accompanies mental health diagnoses and treatment, especially for those in ministry. Finally, section eight will examine the role that clergy burnout plays on depression.

### **Pastors with Depression: In Their Own Words**

In reviewing literature containing first-hand accounts of pastors with depression, several common themes emerged. Challenges presented by incongruence, the need to perform, a feeling of isolation, pressure, and boundary issues appear throughout literature containing first-hand accounts of those in ministry with depression. This section will consider these common themes and support them with the words of Robert Griggs, who served the United Church of Christ for thirty years, worship leader Brian Johnson from Bethel Church, Matt Rogers, co-pastor of New Life Christian Fellowship, and Dr. Gary Lovejoy who has counseled many pastors in his private practice. Although these authors come from varied backgrounds, the common themes found in their accounts provides useful information in the study of pastors with depression.

#### **Incongruence**

Although some studies report as many as seven out of ten pastors suffer from depression, many will attempt to treat their symptoms without disclosing their struggles to anyone else.<sup>26</sup> The reasons for such secrecy vary from pastor to pastor, but regardless of the reasons, Gary Lovejoy notes, “they routinely disguise it, privately pleading with God to help them control their terrifying implosion, to heal them from the fatal flaw of despair that threatens their ministry.”<sup>27</sup> This need to hide their feelings can lead to incongruence which is a theory of personality development proposed by Carl Rogers in which internal conflict arises as one’s public self is greatly different from one’s private, or internal self. The space created between the two can lead to depression and anxiety.

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<sup>26</sup> Lovejoy, *A Pastor's Guide for the Shadow of Depression*, 9.

<sup>27</sup> Ibid.

Although many pastors suffer from depression, many feel the need to conceal their struggles. This may be because some view depression as a result of lack of faith, or hidden sins, both of which could cause congregants to lose faith in their pastor's ability to lead. Lovejoy notes, "Though depression is common among pastors, they are sometimes the last ones to recognize it or, at least, openly admit to it. Part of the problem is that no one expects pastors to be struggling with depression. Instead, they think that, because their walk with God is so strong, pastors will always find refuge in their faith, as if pastors always live above the fray."<sup>28</sup> Such expectations for pastors to *live above the fray* could reinforce the need for them to attempt to conceal their struggles with depression.

Pastors may go to great lengths to maintain a façade of faith and strength because they fear being perceived as unauthentic. Such pressure led to Robert Griggs spending a significant amount of time in a mental health hospital after a major depressive episode with suicidal ideations. Griggs notes, "I couldn't stand the thought that I would be found out as a phony and be ridiculed in front of my congregation."<sup>29</sup> Not only can incongruence lead to symptoms of depression, the need to maintain the appearance that all is well, coupled with fear of congregants finding out the truth can lead to greater symptoms of depression.

One factor that leads to incongruence is unattended wounds that have not been appropriately processed. Those in ministry have struggles and hurts just like anyone else in the church, but are often so busy acting as if they do not have struggles that they never actually attend to those hurts, which eventually turn into wounds. Lovejoy posits, "Unattended wounds

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<sup>28</sup> Lovejoy, *A Pastor's Guide for the Shadow of Depression*, 49.

<sup>29</sup> Robert W. Griggs, *A Pelican in the Wilderness: Depression, Psalms, Ministry, and Movies* (Eugene, Oregon: Cascade Books, 2014), 4.

festering deep under the surface inevitably wear down the brave façade of peace and reassurance believed necessary for a minister who wishes to portray the mind of God.”<sup>30</sup> If pastors do not deal with these unattended wounds they may falsely believe they are getting better as noted by Brian Johnson, “I thought I had been getting better, but clearly I wasn’t. Without my pills, I couldn’t function. I was only treating the symptoms of my breakdown, but there were some underlying problems I clearly hadn’t dealt with.”<sup>31</sup>

Pastors must find a way to live authentically, not denying their wounds, while at the same time not allowing such hurts to negatively affect the ministry. Lovejoy notes, “Really knowing and respecting yourself – what psychologists refer to as ‘self-esteem’ – means, in part, that there is no need for the double life because you feel the freedom to live authentically before others.”<sup>32</sup> Although many pastors desire to live authentically, the fear of doing so leads to incongruence. Additionally, failure to discuss depression among Christians may lead to a skewed perception of depression among believers. Lovejoy warns, “By dismissing – either directly or indirectly – the importance of discussing depression among believers, we inadvertently convey either a profound fear of emotional disorders or a naïve view of the Christian life as one without struggle.”<sup>33</sup>

### Performance

Just as many pastors feel the need to hide their struggles with depression, a second common theme is the need for performance. Many of the pastors treated by Lovejoy at his private counseling practice have settled for being loved for what they do instead of being loved

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<sup>30</sup> Lovejoy, *A Pastor's Guide for the Shadow of Depression*, 27.

<sup>31</sup> Brian Johnson, *When God Becomes Real*, 90.

<sup>32</sup> Lovejoy, *A Pastor's Guide for the Shadow of Depression*.

<sup>33</sup> *Ibid.*, 15.



for who they are. Lovejoy notes, “Performance becomes the all-absorbing focus. They long to be loved for who they are. But frankly, they don’t expect it. Instead, they pin their hopes on being loved for what they do.”<sup>34</sup>

Many pastors not only fall into a performance-based mindset, but also pursue perfection. Brian Johnson of Bethel Music notes, “there is a fine line between excellence and perfection, and I often moved back and forth across that line. I wanted them to make it excellent, but the standard created intense pressure for the entire team. And although I loved the sound that resulted from the drive for excellence, it still came at a cost.”<sup>35</sup> One way to combat perfectionism in worship proposed by Johnson is to realize what authentic worship is noting, “I leaned into this truth: worship is more than singing songs to God; it’s investing in our relationship with Him, even when we don’t feel like it or when circumstances are difficult.”<sup>36</sup>

Griggs proposes one contributing factor to a performance mindset is all or nothing thinking. According to Griggs, “All or nothing thinking forms the basis for perfectionism. It causes you to fear any mistake or imperfection because you will then see yourself as a complete loser, and you will feel inadequate and worthless.”<sup>37</sup>

### Isolation

A third common theme among pastors with depression is isolation. Although many congregants share their struggles with the pastor, few pastors have someone in whom they can confide. Lovejoy notes, “studies show that the overwhelming majority of pastors do not have any

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<sup>34</sup> Lovejoy, *A Pastor's Guide for the Shadow of Depression*, 24.

<sup>35</sup> Johnson, *When God Becomes Real*, 127.

<sup>36</sup> *Ibid.*, 43

<sup>37</sup> Griggs, *A Pelican in the Wilderness: Depression, Psalms, Ministry and Movies*, 44.

close friends, and therefore, no one in whom to confide their troubles.”<sup>38</sup> Lovejoy notes that although pastors are expected to minister to others, they are rarely the recipient of such ministry. Additionally, Rogers notes, “The disease was indeed more of the mind than of the soul, and I likely prolonged my suffering needlessly when help was within reach” indicating that even when the opportunity arises, many pastors are resistant to being ministered to.<sup>39</sup> Rogers acknowledges the minister’s role in isolating themselves, “unrelenting sadness that seemed to have no bottom kept me constantly on the verge of breaking down into a crying fit: my friends were now dead to me; I was alone in a new town where nothing was familiar, nothing was home; God was far away; and I had done this to myself.”<sup>40</sup> Similarly, as Brian Johnson’s circle of friends grew, he actually became more isolated noting, “though we still did life together and hung out with the team all the time, I didn’t dive into a relationship with the key people on the team who really needed it.”<sup>41</sup>

### Pressure

The fourth theme that emerged in research on pastors with depression is the overwhelming pressure that is placed on those in ministry. Speaking of the various roles and responsibilities of pastors, Lovejoy notes, “They are expected to be gifted theologians, crisis management experts, models of emotional stability and spiritual health, and problem-solving servants in the church community.”<sup>42</sup> Lovejoy continues, “Pastors, no less than their

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<sup>38</sup> Lovejoy, *A Pastor's Guide for the Shadow of Depression*, 59.

<sup>39</sup> Rogers, *Losing God: Clinging to Faith through Doubt and Depression*, 121.

<sup>40</sup> *Ibid.*, 66.

<sup>41</sup> Johnson, *When God Becomes Real*, 103.

<sup>42</sup> Lovejoy, *A Pastors Guide for the Shadow of Depression*, 7.

congregations, can ill afford to ignore the principles of cultivating sound mental health. Yet the demands of the church can so easily drown out the voice of reason.”<sup>43</sup>

Brian Johnson also notes the pressure that those in ministry face.

Those were good days even if they were full and complicated. I was balancing so many things – the highs of writing and producing new songs, the pressure of building a ministry, the changing team dynamics, our house remodel, raising a family, managing situations that we didn’t have answers for, leading a team of over one hundred worship team members, and figuring out my role in the middle of it all. But as long as I was still writing, I wasn’t able to see the effects of the strain and pressure. I always thought that once I got through the next thing, the pressure would ease up. But next things never stopped coming. Victories don’t relieve the pressure. The joy I got from my family didn’t fix unresolved issues. Pressure catches up with you, and if you don’t deal with it, eventually you’ll pop.<sup>44</sup>

### Boundaries

The final common theme that emerged among pastors with depression was failure to establish clear boundaries. Griggs notes, “Over the years I had blurred and finally erased the boundary between my church and myself. I had started to treat my church as some kind of extension of my own psyche, where I acted out my own needs and fears.”<sup>45</sup> Lovejoy also notes the blurred boundaries in ministry adding, “For pastors, church is their workplace, and their colleagues are members of the church. In other words, work and fellowship, business and worship are comingled.”<sup>46</sup> Lovejoy warns against the dangers of pastors who allow their relationship with God to become more professional than personal.

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<sup>43</sup> Lovejoy, *A Pastors Guide for the Shadow of Depression*, 18.

<sup>44</sup> Johnson, *When God Becomes Real*, 133.

<sup>45</sup> Griggs, *A Pelican in the Wilderness: Depression, Psalms, Ministry and Movies*, 4.

<sup>46</sup> Lovejoy, *A Pastors Guide for the Shadow of Depression*, 68.

There is always the danger that a pastor's life with God can become more of a professional one than a moment-by-moment one. In other words, a religious one more than a spiritual one. It's in that moment that the impulse of intellectualized faith begins to morph into either a kind of nominalism or a kind of legalism that saps the very vitality that a life in God promises.<sup>47</sup>

Although there are likely many causes for depression in pastors, the common themes of incongruence, the need to perform, isolation, pressure, and lack of boundaries is repeatedly found throughout a review of the literature. The personal accounts of Johnson, Lovejoy, Griggs, and Rogers offer a personal account of pastors who suffer from depression. The implications of their accounts will be further explored in Chapter Four.

### **Diagnostic Criteria for Depression**

#### Historical Perspectives

Prior to 1972, when a group of researchers from Washington University published an article entitled, "Diagnostic Criteria for Use in Psychiatric Research," there was no specified inclusion or exclusion criteria to make psychiatric diagnoses. This article was referred to as the Feighner Criteria, after the lead researcher of the project, as well as the Washington University Criteria, after the academic affiliation of the authors. The article included diagnostic criteria for fifteen disorders the authors considered to be empirically validated.

Although the Feighner Criteria was the first article to address a collection of psychiatric disorders, reports from as early as 1957 can be found to include diagnostic criteria for what was at the time referred to as manic-depressive disorder.<sup>48</sup> The criteria established by Cassidy *et al* required the presence of low mood and at least six out of ten other symptoms including: slow

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<sup>47</sup> Lovejoy, *A Pastors Guide for the Shadow of Depression*, 37.

<sup>48</sup> W Cassidy *et al.*, "Clinical Observations in Manic-Depressive Disease: A Quantitative Study on One Hundred Manic-Depressive Patients and Fifty Medically Sick Controls," *JAMA* 164, no. 15 (1957): 35-46.

thinking, poor appetite, constipation, insomnia, fatigue, loss of concentration, suicidal ideas, weight loss, decreased libido, and agitation.<sup>49</sup> According to Mark Zimmerman *et al.*, “the symptom inclusion criteria identified by the Washington University group have changed relatively little during the past 40 years, thus attesting to the astute observations of these clinical researchers.”<sup>50</sup>

### Current Diagnostic Criteria

Current diagnostic criteria for Major Depressive Disorder (MDD) and other mental health disorders can be found in the American Psychological Association’s *Diagnostic and Statistical Manual, Fifth edition* (DSM-V). According to the DSM-V, a diagnosis of MDD requires the presence of at least five of nine symptoms in the same two-week period and one of the symptoms must be either depressed mood or loss of interest or pleasure. The other symptoms include:

1. Depressed mood most of the day, nearly every day.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.
4. A slowing down of thought and a reduction of physical movement (observable by others, not merely subjective feelings of restlessness or being slowed down).
5. Fatigue or loss of energy nearly every day.
6. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
7. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
8. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

A diagnosis of MDD can be further specified as either having *mixed features* which allows for the presence of manic symptoms as part of the depression diagnosis in patients who do not meet

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<sup>49</sup> W Cassidy *et al.*, “Clinical Observations in Manic-Depressive Disease: A Quantitative Study on One Hundred Manic-Depressive Patients and Fifty Medically Sick Controls,” *JAMA* 164, no. 15 (1957): 35-46.

<sup>50</sup> Mark Zimmerman *et al.*, “How Many Different Ways Do Patients Meet the Diagnostic Criteria for Major Depressive Disorder?” *Comprehensive Psychiatry* 56 (2015): 29.

the full criteria for a manic episode, as well as *with anxious distress* which may affect prognosis, treatment options, and the patient's response to them. Because the diagnostic criteria for MDD is so broad, there are a total of 227 possible combinations for someone to meet diagnostic criteria. This may be why the symptoms of MDD can vary greatly from one person to another.

#### Differentiation from Other Mental Health Disorders

Major Depressive Disorder is not the only mental health disorder that includes depressed mood. Bipolar 2 Disorder as well as Dysthymia also present with similar symptomology. Although various forms of depression have similar symptoms (issues with sleep, low energy, low self-esteem, poor concentration, difficulty making decisions, and feelings of hopelessness) the duration of the symptoms is a major differentiating criterion. For example, when the symptoms of MDD are present for more than two years, the client meets criteria for Dysthymia, which is also known as persistent depressive disorder. According to Laura Greenstein, "While someone with major depressive disorder will typically 'cycle' through episodes of feeling severely depressed and then be symptom-free for periods of time, dysthymia presents with persistent symptoms for years."<sup>51</sup> It is possible to patients to experience double-depression in which someone with dysthymia concurrently meets criteria for MDD. Once the MDD episode is over, the patient continues to meet criteria for Dysthymia. According to Greenstein, seventy-five percent of patients with Dysthymia will experience this type of double-depression.

Bipolar-2 Disorder is another mental health condition that includes symptoms of depression. The differentiating criteria for Bipolar-1 and Bipolar-2 disorder is the presence of a major depressive episode in Bipolar-2 disorder. According to Markus MacGill, "People with

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<sup>51</sup> Laura Greenstein, "Understanding Dysthymia," National Alliance on Mental Illness, January 17, 2018, <https://www.nami.org/Blogs/NAMI-Blog/January-2018/Understanding-Dysthymia>.

major depressive disorder do not experience any extreme, elevated feelings that doctors would classify as mania or hypomania.”<sup>52</sup>

### Differentiation Between Grief, Sadness, and MDD

Although there are clear diagnostic criteria for MDD, recent studies, such as that done by Ruscio and Ruscio indicate the efficacy of viewing depression on a continuum of depressive states.<sup>53</sup> Others such as Mario Maj hold to more clearly defined lines between sadness that many people feel and clinical levels of depression.<sup>54</sup> Maj posits,

We are left, therefore, with two competing approaches: a “contextual” approach, which assumes that the differential diagnosis between “true” depression and “normal” sadness should be based on the presence or not of a triggering life event and on whether the response is proportionate to that event in its intensity and duration; and a “pragmatic” approach, positing that the boundary between depression and “normal” sadness should be based on issues of clinical utility (i.e., thresholds should be fixed – in terms of number, intensity and duration of symptoms, and degree of functional impairment – which are predictive of clinical outcomes and treatment response).<sup>55</sup>

Regarding the effects of grief on the diagnostic criteria for MDD, the significant changes to the DSM-V pertaining to bereavement-related depression is a point of controversy among mental health professionals.<sup>56</sup> Experiencing sadness after the loss of a loved one is a natural

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<sup>52</sup> Markus MacGill, “The Differences between Bipolar and Depression,” *Medical News Today* (February 2019), <https://www.medicalnewstoday.com/articles/314582.php>.

<sup>53</sup> J. Ruscio and A.M. Ruscio, “Informing the Continuity Controversy: A Taxometric Analysis of Depression,” *Journal of Abnormal Psychology* 109 (2000): 473-87.

<sup>54</sup> Mario Maj, “The Continuum of Depressive States in the Population and the Differential Diagnosis Between “Normal” Sadness and Clinical Depression,” in *Sadness or Depression? History, Philosophy and Theory of the Life Sciences*, ed. J Wakefield and S Demazeux (Dordrecht: Springer, 2016), 15:29-38.

<sup>55</sup> *Ibid.*

<sup>56</sup> Clesse Florence *et al.*, “Bereavement-Related Depression: Did the Changes Induced by Dsm-v Make a Difference? Results from a Large Population-Based Survey of French Residents,” *Journal of Affective Disorders* 182 (2015): 82-90.

phenomenon that shares common symptomology such as intense sadness, withdrawal, and changes in appetite, with major depression, yet grief-based sadness does not meet diagnostic criteria for MDD because of the precipitating loss of a loved one.<sup>57</sup> Clesse *et al* note, “Clinicians are faced with the challenge of not over-diagnosing depression in persons who are going through normal grief while at the same time ensuring not to under-diagnose and miss real major depressive episodes triggered by mourning, with the serious complications that entails if left untreated.<sup>58</sup> The DSM-IV and DSM-IV TR included bereavement as an exclusion criterion for a major depressive episode, but the DSM-V removed such exclusion criteria for bereavement and replaced it with a footnote indicating that a major loss can trigger symptoms which mimic a major depressive episode. Additionally, Karam *et al* found that bereavement-related depression has the same clinical profile as other major depressive episodes.<sup>59</sup> Regarding the removal of the bereavement clause in the DSM-V, Kavan and Barone warn, “not only is the grieving patient now stigmatized with a mental-health disorder, but clinicians may unnecessarily prescribe antidepressant medications, exposing patients to the associated adverse effects.”<sup>60</sup>

### **The Role of Clergy in Mental Health Treatment**

According to research conducted by McRay, McMinn, Wrightsman, Burnett, & Ho, members of faith communities have historically depended on pastors for spiritual guidance and counsel.<sup>61</sup> Similarly, Farrell and Goebert found that many Americans with mental health

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<sup>57</sup> *Ibid.*, Florence *et al.*

<sup>58</sup> *Ibid.*

<sup>59</sup> E.G. Karam *et al.*, “Bereavement Related and Non-Bereavement Related Depressions: A Comparative Field Study,” *Journal of Affective Disorders* 112 (2009): 102-10.

<sup>60</sup> Michael G. Kavan and Eugene J. Barone, “Grief and Major Depression -- Controversy Over Changes in Dsm-5 Diagnostic Criteria,” *American Family Physician* 90, no. 10 (November 15, 2014).



concerns preferentially get help from clergy over and against mental health professionals.<sup>62</sup> This tendency to seek help from clergy before mental health professionals has led researchers such as Oppenheimer, Flannelly, and Weaver to identify clergy as gatekeepers to mental health in their congregations.<sup>63</sup>

In a study conducted by Stanford and McAlister, 57.6 percent of respondents indicated the church was “not at all” involved during their time of crisis.<sup>64</sup> One reason for this may be because clergy do not feel adequately trained to address such issues. Farrell and Goebert found that 71 percent of clergy felt inadequately trained to address the mental health needs of those who came to them for help, yet less than 10 percent of those who come to ministers for help with such conditions are referred to mental health professionals.<sup>65</sup> Another study by Stanford indicated, “a high percentage (approximately 30%) of mentally ill Christian congregants who seek counsel from the Church have interactions that are counterproductive to successful treatment.”<sup>66</sup> This could be the result of the pastor’s thoughts on mental health. Payne notes, “A pastor’s beliefs about the spiritual definition and etiology of depression can both facilitate and

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<sup>61</sup> B.W. McRay *et al.*, “What Evangelical Pastors Want to Know About Psychology,” *Journal of Psychology and Theology* 29 (2001): 99-105.

<sup>62</sup> J.L. Farrell and D.A. Goebert, “Collaboration between Psychiatrists and Clergy in Recognizing and Treating Serious Mental Illness,” *Psychiatric Services* 59 (2008): 437-40.

<sup>63</sup> J.E. Oppenheimer, K.J. Flannelly, and A.J. Weaver, “A Comparative Analysis of the Psychological Literature On Collaboration between Clergy and Mental-Health Professionals – Perspectives from Secular and Religious Journals: 1970–1999,” *Pastoral Psychology* 53 (2004): 153-62.

<sup>64</sup> Matthew Stanford and Kandace McAlister, “Perceptions of Serious Mental Illness in the Local Church,” *Journal of Religion, Disability and Health* 12, no. 2 (2008): 151.

<sup>65</sup> D.W. Lowe, “Counseling Activities and Referral Practices of Ministers,” *Journal of Psychology and Christianity* 5 (1986): 22-29.

<sup>66</sup> Stanford & McAlister, *Perceptions of Serious Mental Illness in the Local Church*, 148.

hinder treatment for the community members they serve.”<sup>67</sup> Conversely, mental health professionals’ thoughts on a pastor’s ability to meet the mental health needs of their congregants are found in their unwillingness to refer clients with issues pertaining to faith and religious dynamics to clergy.<sup>68</sup>

There is a significant amount of research regarding the role of clergy in mental health treatment which indicates the importance of creating an inclusive environment for congregants who suffer from mental health issues. White *et al* posit an inclusive and affirming religious support system not only aids in the recovery of mental health conditions, but in the prevention of such conditions.<sup>69</sup> According to Whitehead, instead of fostering an inclusive environment, the church has often modeled the account of the Geresene demoniac found in the fifth chapter of the Gospel of Mark. Whitehead notes, “restrained, chained, subdued, and shackled: in the moment of his need, the community felt the best way to deal with the person’s form of difference was conformance through chains and shackles.”<sup>70</sup> Whitehead continues, “instead of understanding, we sometimes shackle people with particular expectations and restrain them to maintain normalcy. So much so, that at times the only choice, or only seemingly safe space, is one of isolation.”<sup>71</sup>

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<sup>67</sup> Jennifer Shepard Payne, “Variations in Pastors’ Perceptions of the Etiology of Depression By Race and Religious Affiliation,” *Community Mental Health Journal* 45, no. 5 (June): 364, <http://dx.doi.org/10.1007/s10597-009-9210-y>.

<sup>68</sup> M.R. McMinn *et al.*, “Factors Affecting Clergy-Psychologist Referral Patterns,” *Journal of Psychology and Theology* 33 (2005): 299-309.

<sup>69</sup> Scott White *et al.*, “Christians and Depression: Attributions as Mediators of the Depression-Buffering Role of Christian Social Support,” *Journal of Psychology and Christianity* 22 (2003): 49-58.

<sup>70</sup> Jason C. Whitehead, “Ghosts and Guests: A Pastoral Theology Of Belonging For Ministry With Persons With Mental Illness,” *Journal of Pastoral Care & Counseling: Advancing theory and professional practice through scholarly and reflective publications* 70, no. 4 (undefined): 262. <http://dx.doi.org/10.1177/1542305016680627>.

<sup>71</sup> Ibid.

### **Denominational Differences Regarding Mental Health**

There are significant differences in the perceived relationship between religion and mental illness among the Protestant Christian denominations. Researchers such as Hartog and Gow refer to these differences as being on a continuum with conservative and liberal denominations on opposing poles.<sup>72</sup> To the fundamentalist, much of mental and emotional suffering is due to sin or moral failings; therefore therapy, to address such suffering, should consist primarily of confession and forgiveness.<sup>73</sup> Liberal Protestants, however, do not deny the reality of a separate mental-health entity and recognize that there are psychological, as well as spiritual, dimensions to human life; and therefore, not all personal problems have religious solutions.<sup>74</sup> Similarly, research by Payne found, “Mainline Protestants were more likely to view depression in line with mental health professionals: they were more likely to see depression as having a biological component, and more likely to see it as being separate from a religious issue.”<sup>75</sup> Webb’s research found, Roman Catholics reported fewer spiritually oriented causes for mental illness and less skepticism toward the use of secular mental health interventions than either Protestants or nondenominational research participants. United Methodist clergy surveyed by Lafuze, Perkins, and Avirapattu had, “an informed, scientifically based understanding of the causes of mental disorders and the importance of medications in effective treatment.”<sup>76</sup> Also

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<sup>72</sup> K Hartog and K.M. Gow, “Religious Attributions Pertaining to the Causes and Cures of Mental Illness,” *Mental Health, Religion and Culture* 8 (2005): 263-76.

<sup>73</sup> Ibid.

<sup>74</sup> Ibid.

<sup>75</sup> Jennifer Shepard Payne, “Variations in Pastors’ Perceptions of the Etiology of Depression By Race and Religious Affiliation,” *Community Mental Health Journal* 45, no. 5 (June): 363, <http://dx.doi.org/10.1007/s10597-009-9210-y>.

<sup>76</sup> J.E. Lafuze, D.V. Perkins, and G.A. Avirappattu, “Pastors’ Perceptions of Mental Disorders,” *Psychiatric Services* 53 (2002): 91.

regarding more liberal Protestant denominations, Payne found that 99.2 percent of Anglican respondents and 100 percent of Roman Catholic respondents disagreed that “mental illnesses are caused by evil spirits,” but only 75.7 percent of Evangelical/Pentecostal respondents disagreed with the statement.<sup>77</sup>

Various denominational differences in regards to faith and sin may influence one’s views of religion and mental health. Webb notes,

It seems that among certain segments of the Christian population, particularly more conservative groups, psychological distress and disorder are not expected elements of Christian life. They are considered demonstrations of lack of faith or other sin, or the result of demonic influence. Similarly, when Christians do experience psychological distress or disorder, the emphasis may be on willpower and positive thinking to achieve psychological stability.<sup>78</sup>

Webb also found, “Pentecostals in the United States responded to a survey listing possible causes and cures of depression, and reported that they were only ‘somewhat sure’ that ‘spiritual failure’ was a cause of depression, citing other major causes as more important to the etiology of the disorder. Even so, among 32 individual causes listed, demonic oppression/possession was the fourth highest cause endorsed.”<sup>79</sup> Trice and Bjorck found in a survey of 230 Pentecostals in training for full-time ministry that, when asked about the causes and cures of major depression, they accurately endorsed a number of potential non-spiritual causal factor, but saw spiritual discipline and faith as the most effective treatment options.<sup>80</sup> Research by Payne found

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<sup>77</sup> Jennifer Shepard Payne, “Variations in Pastors’ Perceptions of the Etiology of Depression By Race and Religious Affiliation,” *Community Mental Health Journal* 45, no. 5 (June): 363, <http://dx.doi.org/10.1007/s10597-009-9210-y>.

<sup>78</sup> Marcia Webb, “Toward a Theology of Mental Illness,” *Journal of Religion, Disability and Health* 16, no. 1 (2012): 52.

<sup>79</sup> *Ibid.*

Pentecostals in particular were more likely to view depression as an issue that depends on the situation and felt depression was strongly influenced by spiritual causes.<sup>81</sup> Although some denominations are more likely than others to cite sin as the etiology of depression, Scrutton posits,

It seems that moralizing perceptions of depression and other forms of mental illness in Christian contexts are not only intellectually problematic, but also (in spite of some benevolent intentions to empower and give hope) pastorally and therapeutically counter-productive, because they exacerbate the depressed person's feelings of blame, lead to judgmental and alienating behaviors on the part of communities who might otherwise be a source of support, and induce apathy in relation so social justice.<sup>82</sup>

### **Treatment Options**

Although there is a considerable amount of research pertaining to treatment options for depression, there is limited research regarding the treatment options for Christians who struggle with depression. Debates over etiological aspects of depression are likely to affect which, if any, treatment options are suggested by clergy. Payne notes, "It is logical that the counseling that clergy provide for depression will be heavily influenced by the views they have about depression."<sup>83</sup>

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<sup>80</sup> P.D. Trice and J.P. Bjorck, "Pentecostal Perspectives on Causes and Cures of Depression," *Professional Psychology Research and Practice* 37 (2006): 283-94.

<sup>81</sup> Jennifer Shepard Payne, "Variations in Pastors' Perceptions of the Etiology of Depression By Race and Religious Affiliation," *Community Mental Health Journal* 45, no. 5 (June): 363, <http://dx.doi.org/10.1007/s10597-009-9210-y>.

<sup>82</sup> Anastasia Philippa Scrutton, "Is Depression a Sin or a Disease? A Critique of Moralizing and Medicalizing Models of Mental Illness," *Journal of Disability and Religion* 19, no. 4 (2015): 296.

<sup>83</sup> Jennifer Shepard Payne, "Variations in Pastors' Perceptions of the Etiology of Depression By Race and Religious Affiliation," *Community Mental Health Journal* 45, no. 5 (June): 363, <http://dx.doi.org/10.1007/s10597-009-9210-y>, 356.

The church has historically failed to foster a healing environment for those suffering with mental health issues. Hartog notes, “Prior to the 18<sup>th</sup> century, social and religious sanctions ensured that the mentally ill were isolated and treated with both fear and neglect.”<sup>84</sup> Although social and religious sanctions are not commonly imposed on those who struggle with mental health issues today, there are still ministers who dismiss congregants who battle depression. A study conducted by Stanford and McAlister found, “individuals in the local church are denying or dismissing a high percentage (41.2%) of mental disorder diagnoses. In addition, those individuals whose mental illness is dismissed are being told that their psychological and emotional distress results solely from spiritual factors and that medication is not necessary and should not be taken as treatment.”<sup>85</sup>

Although some ministers are dismissive of mental health issues, studies show those who suffer from such issues benefit from an integrative approach. A study by Payne, Bergin, and Loftus found that religion is almost as integral to the religious client as their family structures and relationships.<sup>86</sup> Research by Sreevani *et al* found that an integrative approach to the treatment of depression resulted in improved outcomes as compared with treatment as usual.<sup>87</sup> The effects of distrust between religious communities and mental health providers is identified

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<sup>84</sup> Hartog and Gow, “Religious Attributions Pertaining to the Causes and Cures of Mental Illness,” 264.

<sup>85</sup> Stanford & McAlister, *Perceptions of Serious Mental Illness in the Local Church*, 151.

<sup>86</sup> I. Reed Payne, Allen E. Bergin, and Patricia E. Loftus, “A review of attempts to integrate spiritual and standard psychotherapy techniques.,” *Journal of Psychotherapy Integration* 2, no. 3 (undefined): 171-92, <http://dx.doi.org/10.1037/h0101254>.

<sup>87</sup> Rentala Sreevani *et al.*, “Effectiveness of Integrated Body–Mind–Spirit Group Intervention on the Well-Being of Indian Patients With Depression,” *Journal of Nursing Research* 21, no. 3 (October): 179-86, <http://dx.doi.org/10.1097/jnr.0b013e3182a0b041>.

by Nickerson, Helms, & Terrel, who note, the stereotypical beliefs fostered by religious communities has influenced the uptake, or non-uptake of mental health services.<sup>88</sup>

One area of debate among treatment of mental health disorders is pharmacological treatment and use of psychotropic medications. Because some in the religious community view mental health issues as the result of sin, recommended interventions focus around confession and deliverance. Scrutton notes, “In addition to the fact that sin views tend to exacerbate depression by exacerbating feelings of guilt, believing someone to be sinful is likely to lead to less friendly, more avoiding behaviors, and so to further the alienation of the person from otherwise potentially supportive social structures such as church communities.”<sup>89</sup>

Speaking of pharmacologically treating his anxiety, Carlos Whittaker notes, “This has nothing to do with whether I believe in Jesus... This does not have anything to do with whether or not I am reading my Bible or how hard I am praying. I can pray 24 hours a day, seven days a week, and I’m still going to have to take that little white pill every single day.”<sup>90</sup> Similarly, well known evangelist, Billy Graham notes,

The Bible says that we are ‘fearfully and wonderfully made’ (Psalm 139:14) – and it’s true: Our bodies and minds are very complex. Although doctors can’t solve all our problems, we should be grateful that God has enabled them to understand more about our bodies and minds, and has given them new ways to overcome many of our problems. Don’t feel that you are somehow sinning by

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<sup>88</sup> K.J. Nickerson, J.E. Helms, and F. Terrel, “Cultural Mistrust, Opinions About Mental-Illness, and Black Students Attitudes Toward Seeking Psychological Help from White Counselors,” *Journal of Counseling Psychology* 41 (1994): 378-85.

<sup>89</sup> Scrutton, “Is Depression a Sin or a Disease? A Critique of Moralizing and Medicalizing Models of Mental Illness,” 294.

<sup>90</sup> Amanda Holpuch, “Christians and Mental Health,” *The Guardian*, November 13, 2014, <https://www.theguardian.com/world/2014/nov/13/evangelicals-increasingly-putting-faith-in-medicine-to-treat-mental-health-issues>.

seeking treatment for your depression: it would be wrong for you not to seek treatment.<sup>91</sup>

### Cognitive Behavioral Therapy

One of the most common forms of treatment for depression is Cognitive Behavioral Therapy (CBT) developed by Aaron T. Beck in the 1960s. The goal of CBT is to help the client learn the relationships between thoughts, emotions, and behaviors in order to reduce depressive symptoms.<sup>92</sup> Common CBT interventions include identifying and challenging negative automatic thoughts and thinking traps. In its most simplistic form, CBT is the process of identifying thoughts, determining if that thought is rational or irrational, and replacing irrational thoughts with rational thoughts. This process is similar to directives found in 2 Corinthians 10:5 to *take every thought captive*.

Religious CBT (RCBT) is similar to CBT with the exception that participants' religious beliefs and practices are used the process of confronting irrational, or untrue, thoughts and replacing those false thoughts with biblical Truth.<sup>93</sup> A study of 79 depressed individuals conducted by Tulbure, Andersson, Sălăgean, Pearce and Koenig found no differences between those treated with CBT and RCBT.<sup>94</sup> Tulbure *et al* note, "adding religious resources and content to a CBT program for depression can contribute to the initial appeal and trustworthiness of the

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<sup>91</sup> Billy Graham, "Answers," Billy Graham Evangelistic Association, January 9, 2017, <https://billygraham.org/answer/is-it-a-sin-to-be-depressed-the-doctor-says-i-have-a-chemical-imbalance-that-can-be-treated-with-medication-but-my-friend-says-i-just-need-to-pray-and-have-more-faith/>.

<sup>92</sup> Michelle J. Pearce *et al.*, "Effects of Religious Versus Conventional Cognitive-Behavioral Therapy on Gratitude in Major Depression and Chronic Medical Illness: A Randomized Clinical Trial," *Journal of Spirituality in Mental Health* 18, no. 2 (April): 124-44, <http://dx.doi.org/10.1080/19349637.2015.1100971>.

<sup>93</sup> *Ibid.*

<sup>94</sup> Bogdan Tudor Tulbure *et al.*, "Religious versus Conventional Internet-based Cognitive Behavioral Therapy for Depression," *Journal of Religion and Health* 57, no. 5 (November): 1634-48, <http://dx.doi.org/10.1007/s10943-017-0503-0>.



treatment for the religious participants. However, using such religious resources did not confer further advantages in terms of greater symptom reduction or treatment adherence.”<sup>95</sup> Pearce, Koenig, Robins, Daher, Shaw, Nelson, Berk, Belinger, Cohen, and King studied the effects of gratitude on individuals being treated with CBT and RCBT and found that both treatment forms yielded similar results finding that helping patients develop gratitude is an effective way to reduce depressive symptoms.<sup>96</sup>

### Mindfulness-Based Cognitive Therapy

Mindfulness-based Cognitive Therapy (MBCT) is an empirically supported treatment developed by John Teasdale, Zindel Segal, and Mark Williams, in 2000, as the result of an initiative to reduce depression relapse.<sup>97</sup> According to Rosales and Tan, “the goal of MBCT becomes decentering from the emotional experience by engaging the *being* mode of mind rather than the *doing* mode.”<sup>98</sup> While the goal of CBT is to restructure maladaptive cognition, the goal of MBCT is to become more aware of such experiences.<sup>99</sup> According to Rosales and Tan, MBCT has been proven effective in not only patients with depression, but also anxiety, suicidal ideations, and bipolar disorder.<sup>100</sup>

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<sup>95</sup> Ibid., 1645.

<sup>96</sup> Pearce *et al.*, “Effects of Religious Versus Conventional Cognitive-Behavioral Therapy on Gratitude in Major Depression and Chronic Medical Illness: A Randomized Clinical Trial.”

<sup>97</sup> Aaron Rosales and Siang-Yang Tan, “Mindfulness-Based Cognitive Therapy (Mbct): Empirical Evidence and Clinical Applications from a Christian Perspective,” *Journal of Psychology and Christianity* 36, no. 1 (2017): 76-82.

<sup>98</sup> Ibid., 76.

<sup>99</sup> Ibid.

<sup>100</sup> Ibid.

As the name implies, one emphasis of MBCT is contemplation. Rosales and Tan note, “although Christian contemplative practices can play a central role that parallels MBCT processes, a successful adaptation for Christians would utilize passages such as 1 Corinthians 10:31 to highlight the importance of seeking God in all things we do.”<sup>101</sup> Although strict proponents of MBCT understand mindfulness as *the* way, Christians may understand mindfulness as one way to increase his or her awareness of God by acknowledging, “the present moment is filled with not only the presence of God, but also hope rooted in Christ’s life, death, and resurrection behind—and new creation in which every tear will be wiped away ahead.”<sup>102</sup>

### Centering Prayer

Although some aspects of MBCT can be adapted from its Eastern religious roots and effectively utilized by Christians, Joshua Knabb suggests a similar approach, centering prayer, as another alternative form of treatment for relapse prevention. Knabb notes,

Centering prayer overlaps considerably with MBCT in several ways; however, more importantly, centering prayer is rooted in a Western religious tradition rather than an Eastern religious tradition, which may help some Christian psychotherapy clients to fully embrace, that is, to fully believe in, an intervention that is more congruent with their worldview.<sup>103</sup>

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<sup>101</sup> Ibid., 79.

<sup>102</sup> Aaron Rosales and Siang-Yang Tan, “Mindfulness-Based Cognitive Therapy (Mbct): Empirical Evidence and Clinical Applications from a Christian Perspective,” *Journal of Psychology and Christianity* 36, no. 1 (2017): 80.

<sup>103</sup> Joshua J. Knabb, “Centering Prayer as an Alternative to Mindfulness-Based Cognitive Therapy for Depression Relapse Prevention,” *Journal of Religion and Health* 51, no. 3 (November): 909, <http://dx.doi.org/10.1007/s10943-010-9404-1>.

Centering prayer was developed in the 1970s by three Trappist monks at St. Joseph's Abbey in Spencer, Massachusetts and is largely based on the teachings of *The Cloud of Unknowing*, which was a 14<sup>th</sup> century English book that developed out of the monastic Catholic tradition.<sup>104</sup>

According to Knabb, centering prayer has three characteristics noting, "it allows the individual to get in touch with his or her *center of being*, beyond logic and reason, which is where God is located; it offers the individual a simple and effortless form of prayer so as to abide with God in the present moment; and it helps the individual to relate differently to his or her thoughts."<sup>105</sup> Knabb notes that among the several benefits of centering prayer are receiving God fully, increasing love, shedding the false self, reducing loneliness, and releasing tension.<sup>106</sup>

#### Emotion Focused Therapy

Emotion-focused therapy (EFT) has been proven in treating maladies such as depression, anxiety, and eating disorders.<sup>107</sup> Several techniques are used to resolve conflicts of the self through EFT. First, empathy and exploration are used to deconstruct the client's worldviews, constructions, and assumptions about self and others.<sup>108</sup> Next, a six-step structured approach is used to help the clients resolve their disowned emotional experiences.<sup>109</sup> Third, the Gestalt two-chair theory is used to resolve inner conflict between opposing aspects of the self.<sup>110</sup> Finally,

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<sup>104</sup> Ibid.

<sup>105</sup> Ibid., 914.

<sup>106</sup> Ibid.

<sup>107</sup> Hardin, Todd. "Redeeming Emotion-Focused Therapy: A Christian Analysis of Its Worldview, Epistemology, and Emphasis." *Religions* 5, no. 1 (March): 323-33. <http://dx.doi.org/10.3390/re15010323>.

<sup>108</sup> Ibid.

<sup>109</sup> Ibid.

<sup>110</sup> Ibid.

unfinished interpersonal issues are resolved through Gestalt's empty chair technique.<sup>111</sup> Christian Emotion-focused therapy (CEFT) takes a Christian approach to the same methodology. Todd Hardin notes, "Those who practice CEFT, like their secular counterparts, can honor clients' personhood and encourage their personal agency while working to reorient them to God through the cross of Christ as they activate, explore, express and reflect on difficult emotional experiences."<sup>112</sup>

### Narrative Therapy

Narrative therapy was formed on the thought that everyone has a perceived life story and helps people achieve personal transformation by changing their perceived life story.<sup>113</sup> Although some see narrative therapy as a therapeutic technique in agreement with Christian faith, there is concern among others that it endorses a postmodern hyper-individualism and rejects traditional doctrines of sin.<sup>114</sup> Narrative therapy begins with the client retelling their story of a problem or difficulty. If the narrative focuses on negative experiences, then it is considered a problem-saturated description.<sup>115</sup> After the client's account has been shared, the therapist may ask for more detail and eventually asks the client to eternalize the problem by naming it, which allows the client to view the problem as being the product of circumstances rather than an intrinsic personality issue.<sup>116</sup>

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<sup>111</sup> Ibid.

<sup>112</sup> Ibid., 328.

<sup>113</sup> Wai-Luen Kwok, "Narrative Therapy, Theology, and Relational Openness: Reconstructing the Connection between Postmodern Therapy and Traditional Theology," *Journal of Psychology and Theology* 44, no. 3 (Fall 2016): 201-12.

<sup>114</sup> Thomas V. Frederick, "Models of Psychotherapy: Implications for Pastoral Care Practice," *Pastoral Psychology* 58, no. 4 (April): 351-63, <http://dx.doi.org/10.1007/s11089-009-0200-3>.

<sup>115</sup> Michael White and David Epston, *Narrative Means to Therapeutic Ends* (New York: Norton, 1990).

The deconstruction of a person's old stories and the reconstruction of new ones is the core of narrative therapy.<sup>117</sup> Kwok notes, "Narrative therapy empowers people to break away from their stereotyped narrative reality. It enables them to see, or realize, a new life-story pattern, which becomes a newly constructed reality for them."<sup>118</sup> It is important to note that in narrative therapy, the counselor serves more as a co-author or editor of the story, rather than a counselor attempting to cure the client.<sup>119</sup> Although some Christians believe that narrative therapy allows the client to make an immoral act appear to be morally acceptable, White posits the client has the autonomy to make a moral choice and accept the consequent responsibility for that choice.<sup>120</sup> Kwok notes, "Narrative therapy aims to pursue a relational openness that enables new understanding, feelings, possibilities, and resources in a client's life."<sup>121</sup>

#### Acceptance and Commitment Therapy

The final approach found in the literature regarding effective therapeutic interventions for Christians with depression is Acceptance and Commitment Therapy (ACT), developed by Stephen C. Hayes and Kirk Strosahl in 1982. ACT places an emphasis on mindfulness, acceptance, metacognition, emotion, dialects, and the therapeutic relationship.<sup>122</sup> Rosales and

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<sup>116</sup> Wai-Luen Kwok, "Narrative Therapy, Theology, and Relational Openness: Reconstructing the Connection between Postmodern Therapy and Traditional Theology."

<sup>117</sup> Robert E. Doan and Thomas Alan Parry, *Story Re-visions: Narrative Therapy in the Postmodern World* (New York, NY: Guilford, 1994).

<sup>118</sup> Kwok, "Narrative Therapy, Theology, and Relational Openness: Reconstructing the Connection between Postmodern Therapy and Traditional Theology.", 204.

<sup>119</sup> Ibid.

<sup>120</sup> White and Epston, *Narrative Means to Therapeutic Ends*.

<sup>121</sup> Kwok, "Narrative Therapy, Theology, and Relational Openness: Reconstructing the Connection between Postmodern Therapy and Traditional Theology.", 207.

<sup>122</sup> Kai G. Kahl, Lotta Winter, and Ulrich Schweiger, "The third wave of cognitive behavioral therapies," *Current Opinion in Psychiatry* 25, no. 6 (December): 522-28, <http://dx.doi.org/10.1097/ycp.0b013e328358e531>.

Tan note, “ACTs emphasis on open and non-judgmental awareness of experience is fundamentally different than CBTs attempts to restructure maladaptive cognition. In fact, ACT avoids labels such as *maladaptive* entirely in preference for viewing clients as *stuck* and not *broken*.”<sup>123</sup>

ACT posits the rigid fusion between cognition, emotion, and behavior is the cause of psychopathology. ACT interventions encourage the client to open up, be present, and do what matters.<sup>124</sup> The concept of opening up involves stepping back and observing thoughts rather than getting entangled in them with the goal of eventually gaining non-judgmental acceptance of thoughts, emotions, and experiences.<sup>125</sup> Next, interventions, using techniques of mindfulness, focus on being fully present in the moment rather than being entangled in past pain or future anxieties.<sup>126</sup> Therapeutic gains in opening up and being present are in an attempt to lead to committed action based on a client’s chosen values.<sup>127</sup> Rosales and Tan note, “it is crucial that these values be both chosen freely by the client as well as differentiated from goals,”<sup>128</sup>

Clinical applications of ACT are easily adapted to a Christian perspective because Hayes, the founder of ACT, comes from a Catholic background and has expressed full support and

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<sup>123</sup> Aaron Rosales and Siang-Yang Tan, “Acceptance and Commitment Therapy (Act): Empirical Evidence and Clinical Application from a Christian Perspective,” *Journal of Psychology and Christianity* 35, no. 3 (2016): 269-75.

<sup>124</sup> Russ Harris, *ACT Made Simple: An Easy-to-read Primer On Acceptance and Commitment Therapy* (Oakland, CA: New Harbinger Publications, 2009).

<sup>125</sup> Ibid.

<sup>126</sup> Rosales and Tan, “Acceptance and Commitment Therapy (Act): Empirical Evidence and Clinical Application from a Christian Perspective.”

<sup>127</sup> Ibid.

<sup>128</sup> Ibid., 270.

desire for greater faith integration with ACT.<sup>129</sup> Knabb has identified seven applications of faith-based ACT. First, through experiential avoidance in which Knabb posits, “Christians may be able to more fully follow Jesus if they are able to endure pain rather than avoid distressing experiences.”<sup>130</sup> Second, a focus on grace, rather than legalism, allows the client to reject the idea one’s identity being tied to thoughts, behavior, or emotions through processes such as mindfulness meditation drawn from practices of desert Christians and monastics that followed.<sup>131</sup> Third, Knabb notes, “for Christians, ACT’s acceptance of unpleasant experience is akin to *bupomone*, or hopeful endurance. However, one divergence from the traditional ACT understanding is an emphasis on future grace and eschatological hope being a source to draw upon for acceptance of the present moment experience.”<sup>132</sup> The fourth application of being present can be achieved through contemplative prayer as an avenue to develop non-judgmental, present moment awareness.<sup>133</sup> According to Knabb, the fifth concept of observing self, “is compatible with Christian spirituality in which there is often an assumption of a more essential self that is often called the soul.”<sup>134</sup> Citing Romans 8:26-27, Rosales and Tan note, “Christians can also rely upon God, the Holy Spirit, as an additional observer who works collaboratively to illuminate the heart and mind and even intercedes with wordless groans and helps in

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<sup>129</sup> Joshua J. Knabb, *Faith-Based ACT for Christian Clients* (New York, NY: Routledge, Taylor & Francis Group, 2016).

<sup>130</sup> *Ibid.*, 271.

<sup>131</sup> *Ibid.*

<sup>132</sup> Rosales and Tan, “Acceptance and Commitment Therapy (Act): Empirical Evidence and Clinical Application from a Christian Perspective,” 271.

<sup>133</sup> Knabb, *Faith-Based ACT for Christian Clients*.

<sup>134</sup> Rosales and Tan, “Acceptance and Commitment Therapy (Act): Empirical Evidence and Clinical Application from a Christian Perspective,” 272.

weakness.”<sup>135</sup> The sixth application of a Christian approach to ACT is values which presents rich opportunities for meaningful faith-based motivation and work with Christian clients.<sup>136</sup> Finally, the concept of committed action encourages the client to take virtue-based action even when trials and hardship comes.<sup>137</sup>

### Biblical Perspectives

Several authors have considered biblical accounts of mental health treatment. Webb notes, “While the Scriptures do not present us with a diagnostic case manual of mental disorders, they allow us to watch God’s people in the context of suffering, and the psychological distress they experience.”<sup>138</sup> Webb examines accounts of Elijah, Naomi, and Jesus in his evaluation of mental health treatment in the Bible. In 1 Kings 19:4, the prophet Elijah begs God for death after experiencing fear and despair, yet God’s response is one of gentleness. According to Webb, “God does not chastise Elijah for his lack of faith, nor prod him to improve his attitude. There is no coaxing of Elijah for increased prayer, nor any goading for repentance from sin. Instead, God approaches the prophet gently, attending to his weary body.”<sup>139</sup> God’s response is actually a biopsychosocial approach to mental health treatment because He first attends to Elijah’s physical needs before attending to his mental or spiritual needs.<sup>140</sup>

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<sup>135</sup> Ibid., 272.

<sup>136</sup> Ibid.

<sup>137</sup> Ibid.

<sup>138</sup> Webb, “Toward a Theology of Mental Illness,” 56.

<sup>139</sup> Ibid.

<sup>140</sup> Ibid.



In the book of Ruth, Naomi is found so full of grief that she renames herself Mara because she has made her life very bitter for herself. Although she publicly blames the Lord for her situation (Ruth 1:21), the community does not chastise her for this view, but instead they hold her up. Ruth remains her selfless companion and Boaz attends to the needs of these two widows. Webb notes “rather than portraying Naomi as a champion of personal willpower, this text reminds us of the need for social support when overcome by psychological distress.”<sup>141</sup>

When considering biblical accounts of psychological distress perhaps none is greater than Jesus in the in Garden of Gethsemane and on the Cross. Jesus was far from stoic in his suffering at Calvary, but instead cried out to God. Webb notes, “Stoicism is not necessary for God’s work: the miracle of God at Calvary was not hindered by Christ’s anguish. It was, after all, a power greater than positive thinking that reanimated lifeless flesh and rolled away the stone.”<sup>142</sup>

Addressing the unique challenges of treatment options for pastors with depression, Unger notes, “The counseling community must become engaged with this population and help ministers understand the mental health diagnosis of depression, acknowledge how depression impacts personal and professional abilities as well as identify effective sources of mental health support for this population.”<sup>143</sup> Similarly, Due and Due note, “On the one hand, mental resilience and psychological stability are often regarded as essential character traits (both by pastors and parishioners), but on the other, many factors inherent in pastoral ministry mitigate against them.

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<sup>141</sup> Ibid., 57.

<sup>142</sup> Ibid., 58.

<sup>143</sup> Lisa Unger, “Depression Rates and Help-Seeking Behavior of Baptist Ministers” (PhD diss., Walden University, 2011), in ProQuest, <http://search.proquest.com/docview/861920178>. 76.

This often leads to a clash of expectations (both internal and external) which can manifest in either acute crises and/or chronic depression.”<sup>144</sup>

Research conducted by Witvliet found that many pastors struggle with issues relating to abandonment issues noting, “Religious strain such as feeling abandoned by God and by one’s congregation during difficult times, increases stress and psychological vulnerability.”<sup>145</sup>

Although there are many treatment options available for ministers battling depression, Walz and Bleuer posit, “Group counseling appears to be the best avenue for helping a large number of clergy family concerns.”<sup>146</sup>

### **Stigma**

Although research pertaining to the most efficacious interventions for pastors who have mental health issues is limited and controvertible, research on stigma associated with mental health treatment is abundant and multifaceted. There is a considerable amount of research indicating that much of the stigma associated with Christians who have mental health disorders centers around the idea that mental health issues are the result of sin and are spiritually based. In a study by Hartog and Gow, more than one third of surveyed congregants from predominately conservative protestant denominations endorsed a demonic etiology of major depression and schizophrenia.<sup>147</sup> This is especially problematic for those in ministry who are expected to exhibit

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<sup>144</sup> Noel Due and Kirsten Due, “Courage and Comfort for Pastors in Need,” *Lutheran Theological Journal* 52, no. 3 (December 2018): 128.

<sup>145</sup> Charlotte vanOyen Witvliet, “Speaking Well in Worship about Mental Illnesses: A Beginner's Guide to Language and Resources,” *Reformed Worship*, June 2018.

<sup>146</sup> Garry R. Walz and Jeanna C. Bleuer, “Clergy Families: The Helpless Forgotten's Cry for Help Answered Through Reality Therapy,” *Vistas Online* (2013), [https://www.counseling.org/docs/default-source/vistas/clergy-families-the-helpless-forgottens-cry-for-help.pdf?sfvrsn=1c17cd2b\\_11](https://www.counseling.org/docs/default-source/vistas/clergy-families-the-helpless-forgottens-cry-for-help.pdf?sfvrsn=1c17cd2b_11). 8.

<sup>147</sup> Hartog and Gow, “Religious Attributions Pertaining to the Causes and Cures of Mental Illness.”

a significant amount of faith, yet Stanford and McAlister warn, “Dismissing the diagnosis of a mental disorder and attributing the symptoms to spiritual factors such as personal sin or the demonic may call into question a person’s faith.”<sup>148</sup> Hartog and Gow note, “While most Protestant religious groups have ‘officially’ renounced belief in the demonic etiology of mental illness, replacing it with natural and psychological explanations, several qualitative studies have revealed that among lay Christians, there are still widespread views of mental illness being caused by separation from God and demonic possession.”<sup>149</sup> This indicates that stigma associated with mental health issues is being reinforced somewhere within the Christian community.

Despite the findings by Hartog and Gow, Scrutton found, “While the idea that depression is a sin (or the result of sin) is still common, campaigns among church communities increasingly encourage becoming more open and accepting of people with mental disorders.”<sup>150</sup> Scrutton posits the thoughts of congregants regarding mental health issues are influential in shaping the person’s experience and a factor in their recovery or non-recovery.<sup>151</sup> The thoughts of congregants in Christian churches may be shaped by church websites found by Scrutton which posit depression is the result of a sinful reaction to any type of common problem in life. Scrutton continues, “Moralizing accounts are not limited to websites, but also include Christian self-help books, some of which are bestsellers and some of which are written by professional psychologist or psychiatrists.”<sup>152</sup> Regarding depression author and evangelist Joyce Meyer notes, “Satan uses

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<sup>148</sup> Matthew Stanford and Kandace McAlister, “Perceptions of Serious Mental Illness in the Local Church,” *Journal of Religion, Disability and Health* 12, no. 2 (2008): 151.

<sup>149</sup> Hartog and Gow, “Religious Attributions Pertaining to the Causes and Cures of Mental Illness,” 264.

<sup>150</sup> Anastasia Philippa Scrutton, “Is Depression a Sin or a Disease? A Critique of Moralizing and Medicalizing Models of Mental Illness,” *Journal of Disability and Religion* 19, no. 4 (2015): 285.

<sup>151</sup> *Ibid.*

<sup>152</sup> *Ibid.*, 290.

depression to drag millions into the pit of darkness and despair.”<sup>153</sup> Meyer also posits, “God is certainly positive, and to flow with Him, you must also be positive,” yet this thought is not scripturally supported.<sup>154</sup> Author and teacher Beth Moore also shares her thoughts on depression in her books positing, “I believe it’s one of his [the devil’s] specialties because his fingerprints are all over it.”<sup>155</sup> These famous authors are viewed as biblical experts by many congregants who likely assume their thoughts are biblically based, which could be adding to the stigma of Christians with depression. Research by Hartog and Gow found that 36.6percent of Christians surveyed believed that depression is the result of demonic possession.<sup>156</sup> Speaking from firsthand experience, Ken Camp notes, “When dealing with people in the church...some see mental illness as a weakness—a sign you don’t have enough faith. They said, ‘It’s a problem of the heart. You need to straighten things out with God.’ They make depression out to be a sin, because you don’t have the joy in your life a Christian is supposed to have.”<sup>157</sup>

Firsthand accounts of stigma associated with Christians and mental health issues are easily found throughout a review of the literature. Following the publication of her autobiography disclosing her bipolar disorder, clinical psychologist, Kay Redfield Jamison notes, “I received thousands of letters from people. Most of them were supportive, but many were exceedingly hostile. A striking number said that I deserved my illness because I was

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<sup>153</sup> Joyce Meyer, *Battlefield of the Mind* (New York, NY: Warner Faith, 1995), 166.

<sup>154</sup> *Ibid.*, 51.

<sup>155</sup> Beth Moore, *Praying God's Word* (Nashville, TN: Broadman and Holman, 2000), 250.

<sup>156</sup> Hartog and Gow, “Religious Attributions Pertaining to the Causes and Cures of Mental Illness.”

<sup>157</sup> Ken Camp, “Through a Glass Darkly: Churches Respond to Mental Illness,” *Baptist Standard*, March 7, 2009, <https://www.baptiststandard.com/archives/2009-archives/through-a-glass-darkly-churches-respond-to-mental-illness/>.

insufficiently Christian and that the devil had gotten hold of me. More prayer, not medication, was the only answer.”<sup>158</sup> Similarly, Norma Swetman, a pastor’s wife who suffers from depression, recalls:

Several church people told my husband that I did not have enough faith or must have a poor relationship with God or that my mental illness was a form of “demon possession.” Because of attitudes that still prevail, I am cautious about sharing my experiences. I fear people will consider me a lesser child of God – although I know that to God none of us is “lesser.”<sup>159</sup>

Unfortunately, such misconceptions are not limited to people outside of the helping profession.

E. Rae Harcum recalls, “A respected social worker once said to me about a mutual friend, ‘If she would just start thinking about others, instead of herself all the time, she would not have so many physical and psychological problems.’”<sup>160</sup> Such accounts could lead to what McGuire and Pace refer to as internalized stigma noting, “A higher level of internalized stigma is associated with less hope, empowerment, self-esteem, self-efficacy, quality of life and social support. In addition, there was a correlation between self-stigma and greater symptom severity and treatment nonadherence.”<sup>161</sup> Research by McGuire and Pace “indicate(s) a higher degree of self-stigma of depression among evangelical Christians than other Christian denominations and the general population.”<sup>162</sup>

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<sup>158</sup> Kay Jamison, “The Many Stigmas of Mental Illness,” *Lancet* (2006): 534.

<sup>159</sup> Kathleen Greider, *Much Madness Is Divinest Sense: Wisdom in Memoirs of Soul-suffering* (Cleveland, OH: Pilgrim Press, 2007), 191.

<sup>160</sup> E. Rae Harcum, *God's Prescription for Your Mental Health: Smile If You Truly Believe Your Religion* (Lanham, MD: Hamilton Press, 2010), Preface.

<sup>161</sup> J. Michael McGuire and Adam C. Pace, “Self-Stigma of Depression in Christians Versus the General Population,” *Mental Health, Religious, and Culture* 21, no. 6 (2018): 601-8.

<sup>162</sup> *Ibid.*, 607.

## Clergy Burnout

According to Schaufeli & Greenglass, burnout can be defined as a state of physical, emotional, and mental exhaustion that is produced after long-term involvement in stressful work situations that are emotionally demanding.<sup>163</sup> Consequences of burnout include depression, somatization, and anxiety disorders among others.<sup>164</sup> Early studies on burnout conducted by Maslach identified three key themes: emotional exhaustion, depersonalization, and lack of a sense of personal accomplishment.<sup>165</sup> According to Bancroft Davis, “Emotional exhaustion is described as having feelings of being emotionally overextended and depleted of one’s emotional resources”<sup>166</sup> Additionally, “Depersonalization is a negative response to people to whom services are being delivered that appears to others as callousness or detachment. Depersonalization arises in the form of outward cynicism or detachment.”<sup>167</sup> Finally, a lack of a sense of personal accomplishment is considered to be the reduction in one's sense of self achievement or competence in regard to one's work.<sup>168</sup> Davis notes, “As the worker assumes that one's efforts are no longer effective, a sense of powerlessness and futility emerges. This leads to unwillingness to take actions and a feeling of lack of accomplishment ensues.”<sup>169</sup>

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<sup>163</sup> Wilmar B. Schaufeli and Esther R. Greenglass, “Introduction to special issue on burnout and health,” *Psychology & Health* 16, no. 5 (October): 501-10, <http://dx.doi.org/10.1080/08870440108405523>.

<sup>164</sup> Ibid.

<sup>165</sup> Christina Maslach and Julie Goldberg, “Prevention of burnout: New perspectives,” *Applied and Preventive Psychology* 7, no. 1 (undefined): 63-74, [http://dx.doi.org/10.1016/s0962-1849\(98\)80022-x](http://dx.doi.org/10.1016/s0962-1849(98)80022-x).

<sup>166</sup> Bancroft G. Davis, “Preventing Clergy Burnout: Assessing the Value of a Mindfulness-Based Intervention as Part of a Holistic Clergy Wellness Program” (PsyD diss., Chestnut Hill College, 2010), in ProQuest, <http://search.proquest.com/docview/820745053>.

<sup>167</sup> Ibid.

<sup>168</sup> Maslach and Goldberg, “Prevention of Burnout: New Perspectives.”

<sup>169</sup> Davis, “Preventing Clergy Burnout.”

Research by Hallsten proposes that there are three factors in both the individual and the environment that contribute to the development of burnout: vulnerability, goal orientation, and perceived environmental congruency.<sup>170</sup> According to Davis, “Vulnerability comes about from the combination of an unstable self-image, a dependence on self-definitional role enactment, and a lack of social support both within and outside of the work environment.”<sup>171</sup> Davis continues, “Goal orientation leads to burnout when one's goals are frustrated. This can be especially problematic when the goal strivings are a form of acting out of the self-definition and are inherently maladaptive in the first place.”<sup>172</sup> Finally, the third factor proposed by Hallsten is perceived environmental congruency, which occurs when there is not enough social support or environmental resources to complete the task at hand.<sup>173</sup>

The most widely used instrument to measure burnout is the Maslach Burnout Inventory (MBI).<sup>174</sup> The MBI was derived inductively from a set of 47 items in a survey of human service workers, from which the original 25-item self-report measure was created using factorial analysis. Although the MBI categorizes the raw score, “The manual for the MBI strongly cautions those interpreting the test to report the original numerical scores rather than the categorizations of *low*, *average*, and *high*.”<sup>175</sup>

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<sup>170</sup> Lennart Hallsten, “Burning Out: A Framework,” in *Professional Burnout*, ed. W. Schaufeli, C. Maslach, and T. Marek (Philadelphia, PA: Taylor & Francis, 1993).

<sup>171</sup> Davis, “Preventing Clergy Burnout,” 16.

<sup>172</sup> Ibid.

<sup>173</sup> Hallsten, “Burning Out: A Framework.”

<sup>174</sup> Wilmar Schaufeli and Dirk Enzmann, *The Burnout Companion to Study and Practice: A Critical Analysis* (London: Taylor & Francis, 1998), 1.

<sup>175</sup> Davis, “Preventing Clergy Burnout.”

There is limited research regarding effective strategies to prevent ministry burnout. The most common recommendations involve mindfulness training. One approach found in the literature is Mindfulness-Based Stress Reduction (MBSR). According to Davis, MBSR training is comprised of classes that include a, “skillful blend of sitting and walking meditation, didactic presentations, gentle Hatha yoga, body scans, and group discussions.”<sup>176</sup> One of the aims of MBSR is to introduce the practice of mindfulness so that it can be used as a skill that can be applied for the purpose of gaining greater regulation of stress and management of emotions.<sup>177</sup> Other effective techniques for treating burnout include previously mentioned approaches of ACT and narrative therapy.

Alydia Smith proposes the use of Resiliency Training as an effective form of treatment specifically for worship leaders to address burnout.<sup>178</sup> Originally used with social workers and nurses, Smith notes,

Resiliency training is a proactive way to prepare clergy for the stresses of ministry by helping them: acknowledge the current context of their ministry (narrative of concern); understand why it is stressful (to find meaning and motivation to engage with the context through theology); and to claim and build on the resiliency tools they already possess (through a resilience training model based on a narrative methodology).<sup>179</sup>

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<sup>176</sup> Davis, “Preventing Clergy Burnout,” 26.

<sup>177</sup> Ibid.

<sup>178</sup> Alydia Rae F. Smith, “Keeping the Fire Burning (Without Getting Burnt): Helping Worship Leaders Maintain Their Passion for Ministry through Resiliency Training” (DMin diss., Drew University, 2015), in ProQuest, <http://search.proquest.com/docview/1678629410>.

<sup>179</sup> Ibid., 4.



Regarding the approach of resiliency training, Smith notes, “Rather than dealing with or focusing on the energy input and output, resiliency training focuses on the person, their experiences, their place in the Christian story and why they want to continue.”<sup>180</sup>

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<sup>180</sup> Ibid., 35.

## CHAPTER THREE: METHODOLOGY

In order to have a thorough understanding of the challenges faced by worship leaders with depression, a comprehensive study of the topic must address the unique challenges faced by ministers with depression, diagnostic criteria for depression, the role of clergy in mental health treatment, treatment options, and stigma associated with ministers with depression. The purpose of this qualitative historical study was to raise awareness of both the etiology and symptomology of depression as well as identify effective forms of support and interventions for the depressed worship leader. The purpose of this chapter is to explain the methodology used to conduct this qualitative historical study. This chapter addresses the specific research design utilized in this study, as well as information regarding the process of gathering and interpreting the literature in an effort to answer the research questions.

### Research Design

The qualitative historical design was implemented in this study to examine the unique challenges faced by worship leaders with depression. According to Creswell, a qualitative research design is appropriate when considering complex aspects of a social or human problem in which the research builds from particular to general themes.<sup>181</sup> Regarding such themes, Creswell notes in a qualitative design, there is a vacillation between themes and findings which eventually leads to organization into more abstract units, thus moving from inductive to deductive thought on the part of the researcher.<sup>182</sup> Further, effort was made to ensure a holistic account by reporting multiple perspectives by intentionally selecting and examining documents for the purpose of understanding both the research problem and research questions, which is a

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<sup>181</sup> John W. Creswell and J David Creswell, *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, fifth ed. (Los Angeles: SAGE, 2018), 4.

<sup>182</sup> *Ibid.*, 182.

key aspect of qualitative design.<sup>183</sup> A qualitative historical approach was implemented because existing literature was collected, examined, and used to make predictions about the efficacy of future interventions.<sup>184</sup>

The process for this qualitative research study began with identifying the problem, which in this case was the unique challenges faced by worship leaders with depression. Next, research questions and corresponding hypotheses were formulated. Existing literature was then collected and reviewed to ensure it was valid, credible, and applicable to the current study.<sup>185</sup> The remaining literature was critiqued, and eventually used to make recommendations regarding the research questions.

### **Research Questions**

The research questions addressed in this study are:

RQ1: What are the unique challenges faced by the worship leader when struggling with depression?

RQ2: In what ways can the church staff support the needs of the worship leader when struggling with depression?

### **Hypotheses**

H1: The challenges unique to worship leaders struggling with depression include: incongruence, doubt, and spiritual warfare.

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<sup>183</sup> Creswell, *Research Design*, 182.

<sup>184</sup> Edward Hallett Carr, *What is History*, (New York, NY: Random House Inc., 1961), 35.

<sup>185</sup> Creswell, *Research Design*.

H2: The church staff can support the needs of worship leaders struggling with depression in terms of: awareness of symptoms, therapeutic interventions, and burnout prevention.

### **Process of Gathering Existing Literature**

In the early stages of research for this study, a gap in the literature was found pertaining to worship leaders who suffer with depression. The first step in the collection process was to select and review relevant, scholarly sources which address pastors with depression and in keeping with Creswell, logically extending that research to make predictions about worship leaders with depression. Upon examination of findings documented in dissertations theses, journal articles, and books, common themes began to emerge. These themes included: pastors with depression which provided insight into the challenges of pastors with depression, diagnostic criteria for various mental health diagnoses which are often considered *depression*, the historic and modern role of clergy in mental health treatment, treatment options for depression, and stigma associated with Christians who struggle with mental health issues.

Numerous books and journal articles were selected which provided narrative accounts of pastors with depression. This allowed the actual words of the pastors to be included in this study and for common themes to emerge. The first theme that emerged was incongruence in which many pastors noted a significant difference between the public, perceived self, and the private, inner self leading to thoughts of inauthenticity and a façade of faith. The second theme that emerged centered around performance. This included both feeling a need to cover up true feelings of depression with a public performance each week, as well as overall performance as a pastor including church attendance and growth. Third, a theme of isolation was also found throughout the first-hand accounts of pastors with depression. The fourth theme that emerged was the great pressure placed on pastors due to the many duties and responsibilities placed on

them. Finally, boundary issues were noted by several pastors in which the lines between work, church, and family were often blurred and crossed. Although much of the literature in this section addressed individual pastors, the repetition of themes from pastor to pastor gives significance to the commonality in thought and struggles.

After a thorough examination of bibliographic accounts of pastors with depression was completed, sources were gathered and examined regarding the diagnostic criteria for depression. Historical perspectives were considered to understand the need for formal diagnostic criteria. Next, a brief study of the current diagnostic criteria for depression was included to validate the thoughts and feelings shared by pastors in the previous section and to differentiate between clinical and non-clinical levels of depression. Because many other mental health disorders are often mistakenly referred to as depression, a section addressing the diagnostic criteria for similar diagnoses was included. Finally, differentiation between grief, sadness, and MDD was further examined to establish the difference between feelings and a diagnosable mental health disorder.

The next area of focus in current research centered on the role of clergy in mental health treatment. This was a significant area of study to determine if the pastor's personal thoughts on mental health issues effected his or her ability to help congregants with mental health issues including referral for professional help. This section offered a thorough examination of current research regarding pastors' thoughts on the etiology of mental health issues as well as effective treatment options. As studies for this section were reviewed, additional themes formed around denominational differences regarding mental health, which became a separate area of focus.

As literature was gathered which addressed pastors with depression, an area of debate over treatment options became apparent. Views on secular versus biblical counseling was one area of division found throughout the literature, as well as the use of pharmacological

interventions. A thorough understanding of debates on these issues is necessary to address any current misconceptions as well as in offering effective recommendations for future treatment options.

The final step in the process of examining current literature involved the collection of research pertaining to stigma associated with pastors with depression. There is a significant amount of research, both recent and older, on the stigma associated with depression in the general public, as well as those in the church – including those in ministry. The prevalence of stigma in the church as well as possible causes for such stigma were examined in order to make appropriate recommendations for how the church can better address depression in not only congregants, but staff members as well.

### **Analysis of Sources**

Care was taken throughout the process of collecting sources to be included in this study. Sources were analyzed for validity and reliability. As sources were deemed acceptable and appropriate for this study, they were compared for a natural emergence of common themes. Converging evidence from multiple sources was identified as credible.<sup>186</sup> First-hand accounts from ministers with depression contained not only common themes, but also unique phenomena for that minister. These unique outliers were not dismissed as irrelevant to this study, but were not considered valid or reliable as they did not meet criteria for such as outlined by Creswell.<sup>187</sup> Discrepant ideas found in quantitative studies were included in this study as Creswell notes, the inclusion of information that is contrary to the current study is one form of offering validity to the current study.<sup>188</sup>

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<sup>186</sup> Creswell, *Research Design*, 200.

<sup>187</sup> Ibid.

### Summarizing the Emerging Themes

According to Creswell, the five-step, systematic process of identifying emerging themes is akin to peeling back the layers of an onion.<sup>189</sup> The first step of Creswell's approach involved organizing the literature by sorting and arranging various findings into different types based on sources of information.<sup>190</sup> Next, the literature was read to allow for general ideas and common themes to emerge, which were often noted in the margins of the research.<sup>191</sup> The third step involved grouping important quotes and thoughts into broad, theme based categories.<sup>192</sup> It was in this step that recurring themes were validated through multiple sources. A description of these themes was created in step four and labels were created to serve as headings in chapter two. Finally, the sources were reviewed again according the thematic groupings identified in step four which led to the identification of common threads and subheadings within each thematic category.

Once emerging themes were gleaned through the process of identifying, gathering, reviewing, coding, and thematic organization, specific areas of research were evaluated to determine how it supported or disproved other areas of research undertaken as part of this study. This process allowed for the findings to be synthesized in a way which allowed for interpretation as a whole as opposed to individual thematic groups. For example, research on stigma associated with mental health conditions was considered in conjunction with narrative accounts of pastors with depression and then filtered through the lens of biblical accounts of those suffering from

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<sup>188</sup> Ibid., 201.

<sup>189</sup> Creswell, *Research Design*, 190.

<sup>190</sup> Ibid., 193.

<sup>191</sup> Ibid.

<sup>192</sup> Ibid.

mental health issues in light of current research on treatment options for depression. Synthesizing and interpreting the current research in this manner allowed the researcher to draw conclusions regarding resistance to mental health treatment as well as make recommendations for effective future interventions for worship leaders with depression.



## CHAPTER FOUR: RESEARCH FINDINGS

This chapter presents the findings of research conducted in an effort to identify the unique challenges faced by worship leaders with depression as well as identify ways in which fellow church staff members can support the needs of a worship leader with depression. In response to the first research question, literature suggests that the challenges unique to ministers with depression include incongruence, doubt, and spiritual warfare. In response to the second research question, literature suggest that church staff can support the needs of worship leaders with depression by awareness of symptoms, therapeutic interventions, and burnout prevention. Research findings which impact each area of the study are presented and discussed.

### **The Unique Challenges of Worship Leaders with Depression**

Depression is a multi-faceted mental health disorder and those who have a diagnosis of Major Depressive Disorder face significant challenges including selecting effective treatment options and stigma. In addition to these challenges, worship leaders with depression may also experience incongruence, doubt, and spiritual warfare; all of which are often played out in plain view of the congregation which they are called to lead in worship each week. This public display of both symptoms and treatment may lead to exacerbated symptomology and reduced response to interventions.

#### Incongruence

As theorized by Carl Rogers, incongruence occurs when the public self and inner self are greatly different. Noel and Kirsten Due define incongruence as a *clash of expectations*.<sup>193</sup> Although incongruence is not unique to worship leaders with depression, research indicates that

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<sup>193</sup> Noel Due and Kirsten Due, "Courage and Comfort for Pastors in Need," *Lutheran Theological Journal* 52, no. 3 (December 2018): 128-40.

parishioners do not expect for their pastor to suffer from depression.<sup>194</sup> This may lead to a pastor attempting to disguise his or her symptoms of depression, thus eliminating the freedom to live authentically before the congregation.<sup>195</sup> Griggs notes that this incongruence may lead to greater levels of depression because the pastor does not want to be perceived as *phony*.<sup>196</sup>

The underlying desire to ensure the congregation does not notice the symptoms of depression may lead to a performance mindset on the part of the worship leader, which is likely to lead to a greater need to present flawless worship sets each week. Lovejoy notes that instead of being loved for who they are, many pastors settle for being loved for what they do.<sup>197</sup> This sentiment is shared with Brian Johnson who notes that worship leaders often fail to find balance between leading with excellence and perfection.<sup>198</sup> Griggs notes a performance mindset may be due to all or nothing thinking in which any mistake or imperfection leads to feelings of inadequacy or worthlessness, both of which are common symptoms of depression.<sup>199</sup> Incongruence and the resulting performance mentality can result in isolation as worship leaders avoid close relationships with others who may see their underlying depression.

### Doubt

The second challenge hypothesized for worship leaders with depression is doubt. Although Griggs, Johnson, and Rogers all noted times when they doubted their level of depression would change, none indicated doubt in God's goodness or His ability to heal or

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<sup>194</sup> Due and Due, "Courage and Comfort for Pastors in Need."

<sup>195</sup> Lovejoy, *A Pastor's Guide for the Shadow of Depression*.

<sup>196</sup> Griggs, *A Pelican in the Wilderness: Depression, Psalms, Ministry, and Movies*, 4.

<sup>197</sup> Lovejoy, *A Pastor's Guide for the Shadow of Depression*.

<sup>198</sup> Johnson, *When God Becomes Real*.

<sup>199</sup> Griggs, *A Pelican in the Wilderness: Depression, Psalms, Ministry, and Movies*.

deliver them from their depression. This study found limited instances of pastors noting doubt as a part of their depression. Again, this does not mean that doubt is not a part of some pastor's struggle with depression, but it was not commonly found in the research which was included in this study.

### Spiritual Warfare

The third challenge which was hypothesized is spiritual warfare. This study found that the aspect of spiritual warfare in depression is more common in fundamentalist Christian denominations. Some Christian denominations believe that depression is the result of a sinful reaction to common problems in life.<sup>200</sup> Research by Trice and Bjorck found that Pentecostals are more likely to view depression as a spiritual issue than other Protestant groups.<sup>201</sup> Similarly, Hartog and Gow found that mainline Protestant denominations are less likely to view depression as a spiritual issue.<sup>202</sup> Additionally, mainline Protestant denominations are more likely to acknowledge the biological component of mental health issues.<sup>203</sup> Roman Catholics were found to be the least likely group among Christians to view depression as a spiritual issue.<sup>204</sup>

### Additional Findings

Although not in the original hypothesis for challenges unique to worship leaders with depression, research indicated two challenges not considered at the onset of this study: pressure and stigma. Johnson, Griggs, and Rogers all noted the pressures that they felt as worship leaders

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<sup>200</sup> Scrutton, "Is Depression a Sin or Disease?"

<sup>201</sup> P.D. Trice and J.P. Bjorck, "Pentecostal Perspectives on Causes and Cures of Depression," *Professional Psychology Research and Practice* 37 (2006): 283-94.

<sup>202</sup> Hartog and Gow, "Religious Attributions Pertaining to the Causes and Cures of Mental Illness."

<sup>203</sup> Payne, "Variations in Pastors' Perceptions of the Etiology of Depression by Race and Religious Affiliation."

<sup>204</sup> Webb, "Toward a Theology of Mental Illness."

and how these pressures exacerbated symptoms of depression and anxiety. Oppenheimer, Flannelly, and Weaver found that clergy is often seen as “gatekeepers” to mental health which leads many clergy members to feel as if they should have a certain level of mental resilience.<sup>205</sup> Similarly, Gary Lovejoy notes that many of the pastors who see him to treat their anxiety and depression admit that the pressure of the demands of ministry easily drown out the voice of reason.<sup>206</sup> Although some pastors may appear to handle such pressures with grace, Johnson warns the pressure eventually catches up with those in ministry.<sup>207</sup>

Another significant challenge found in this study was the stigma associated with pastors with depression. Hartog and Gow, among others, found that many Christians believe that mental health issues are caused by separation from God, which would obviously be a problem for those in ministry.<sup>208</sup> Stanford and McAlister posit that dismissing biological factors and attributing mental health issues of sin or spiritual warfare may call into question a person’s faith, which would also be antithetical to the qualities desired in a pastor.<sup>209</sup> A study conducted by Camp found some parishioners not only believe that depression is due to a lack of faith or sin, but also a lack of joy and view it as a sign of spiritual weakness.<sup>210</sup> Similar thoughts can be found in the teachings of famous Christian authors and teachers such as Beth Moore and Joyce Meyer, whose books are read by millions of Christians thus perpetuating this stigma.

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<sup>205</sup> Oppenheimer, Flannelly, and Weaver, “A Comparative Analysis of the Psychological Literature on Collaboration between Clergy and Mental-Health Professionals.”

<sup>206</sup> Lovejoy, *A Pastor’s Guide for the Shadow of Depression*, 18.

<sup>207</sup> Johnson, *When God Becomes Real*.

<sup>208</sup> Hartog and Gow, “Religious Attributions Pertaining to the Causes and Cures of Mental Illness.”

<sup>209</sup> Stanford and McAlister, “Perceptions of Serious Mental Illness in the Local Church.”

<sup>210</sup> Camp, “Through the Glass Darkly: Churches Respond to Mental Illness.”

## **Forms of Support for Worship Leaders with Depression**

The purpose of this study was not only to identify the unique challenges faced by worship leaders with depression, but to identify effective forms of support from fellow staff members. It was hypothesized that church staff members can support the needs of a worship leader with depression by increased awareness of symptoms, therapeutic interventions, and burnout prevention strategies. Although a review of the literature did not find evidence of these forms of support being offered from one staff member to another, research indicated that awareness of symptoms and effective therapeutic interventions are beneficial to anyone with depression.

### Awareness of Symptoms

With the many demands of ministry, it is possible to not notice the early symptoms of depression. Walz and Bleuer found, “Clergy and their families go through a great deal of stress due to the high expectations put forth on them by the congregation, community, and denominational leaders.”<sup>211</sup> Regarding the expectations placed on those in ministry, Lovejoy notes, “They are expected to be gifted theologians, crisis management experts, models of emotional stability and spiritual health, and problem-solving servants in the church community.”<sup>212</sup> The minister may be so distracted by the demands of ministry that he or she moves from stress to depression without notice. Additionally, research by Lovejoy indicated that isolation and boundary issues also contributed to increased symptomology of depression.

In order to become aware of the symptoms of depression, one must have knowledge of the diagnostic criteria for depression as well as differentiation between depression and non-clinical levels of feelings and emotions that lead to a diagnosis of depression. The process of

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<sup>211</sup> Walz and Bleuer, “Clergy Families: The Helpless Forgotten’s Cry for Help Answered Through Reality Therapy,” 3.

<sup>212</sup> Lovejoy, *A Pastor’s Guide for the Shadow of Depression*, 7.

establishing clear diagnostic criteria for depression began as early as the 1950s, but the Feighner criteria from 1972 had the most influence on the current DSM-V diagnostic criteria. The DSM-V provides clear criteria for the diagnosis of major depressive disorder and differentiates those feelings from feelings of sadness due to loss or grief.

Because the diagnostic criteria for MDD is so broad, there are a total of 227 possible combinations for someone to meet diagnostic criteria. This may be why the symptoms of MDD can vary greatly from one person to another. Further, many symptoms of depression overlap with other mental health disorders such as Bipolar 2 and Dysthymia. As mentioned earlier, the symptoms of MDD may be similar to those after loss or grief. Research by Karam *et al* found that bereavement-related depression has the same clinical profile as major depressive episode.<sup>213</sup>

This study found that denominational differences may have an effect on the recognition of symptoms of depression. Hartog and Gow liken these differences as being on a continuum with more fundamentalist denominations on one pole and liberal denominations on the opposite pole.<sup>214</sup> Webb found that more fundamental denominations were more likely to view mental health issues as the result of sin or lack of faith.<sup>215</sup> Conversely, research conducted by Payne found that 100 percent of Roman Catholic respondents disagreed with the idea that mental illnesses are caused by evil spirits.<sup>216</sup> With such differences regarding the etiology of depressive

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<sup>213</sup> E.G. Karam *et al.*, “Bereavement Related and Non-Bereavement Related Depressions: A Comparative Field Study,” *Journal of Affective Disorders* 112 (2009): 102-10.

<sup>214</sup> Hartog and Gow, “Religious Attributions Pertaining to the Causes and Cures of Mental Illness.”

<sup>215</sup> Webb, “Toward a Theology of Mental Illness.”

<sup>216</sup> Payne, “Variations in Pastors’ Perceptions of the Etiology of Depression by Race and Religious Affiliation.”

symptoms, it is logical that the interpretation of symptoms would vary from one denomination to another.

### Therapeutic Interventions

Debates over etiological aspects of depression are likely to affect which, if any, treatment options are suggested by clergy. Payne notes, “It is logical that the counseling that clergy provide for depression will be heavily influenced by the views they have about depression.”<sup>217</sup> Research by Stanford and McAlister found that as much as 41 percent of members in the local church are dismissing or denying mental health diagnoses.<sup>218</sup>

Although some ministers are dismissive of mental health issues, studies show those who suffer from such issues benefit from an integrative approach. Research by Sreevani *et al* found that an integrative approach to the treatment of depression resulted in improved outcomes as compared with a non-integrative approach.<sup>219</sup> As a part of this study, several treatment approaches were found to be well adapted to a Christian perspective.

Cognitive Behavioral Therapy is commonly used to treat depression by recognizing and challenging negative automatic thoughts and thinking traps. Religious CBT is similar to CBT with the exception that participants’ religious beliefs and practices are used in the process of confronting irrational, or untrue, thoughts and replacing those false thoughts with biblical Truth.<sup>220</sup> Tulbure *et al* note, “Adding religious resources and content to a CBT program for

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<sup>217</sup> Ibid., Payne, 356.

<sup>218</sup> Stanford and McAlister, “Perceptions of Serious Mental Illness in the Local Church.”

<sup>219</sup> Rentala Sreevani *et al.*, “Effectiveness of Integrated Body–Mind–Spirit Group Intervention on the Well-Being of Indian Patients With Depression,” *Journal of Nursing Research* 21, no. 3 (October): 179-86, <http://dx.doi.org/10.1097/jnr.0b013e3182a0b041>.

<sup>220</sup> Pearce *et al.*, “Effects of Religious Versus Conventional Cognitive-Behavioral Therapy.”

depression can contribute to the initial appeal and trustworthiness of the treatment for the religious participants. However, using such religious resources did not confer further advantages in terms of greater symptom reduction or treatment adherence.”<sup>221</sup>

Research conducted by Rosales and Tan found MBCT to be a proven, effective intervention for not only patients with depression, but also anxiety, suicidal ideations, and bipolar disorder.<sup>222</sup> Rosales and Tan note, “although Christian contemplative practices can play a central role that parallels MBCT processes, a successful adaptation for Christians would utilize passages such as 1 Corinthians 10:31 to highlight the importance of seeking God in all things we do.”<sup>223</sup> MBCT focuses on decentering from emotional experiences by moving from a *being* mode of mind to a *doing* mode of mind. Similar in approach to MBCT is centering prayer, which according to Knabb, “allows the individual to get in touch with his or her *center of being*, beyond logic and reason, which is where God is located.”<sup>224</sup> Many Christians have a difficult time engaging in such a heavily Eastern thought.

An additional intervention found in the research to be easily adapted to a Christian approach is narrative therapy. Rooted in the idea that therapeutic benefit can be obtained by changing one’s thought on his or her life story, narrative therapy involves externalizing one’s problems which allows the client to view the problem as being the product of circumstances

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<sup>221</sup> Tulbure, “Religious Versus Conventional Internet-based Cognitive Behavioral Therapy for Depression,” 1645.

<sup>222</sup> Rosales and Tan, “Mindfulness-Based Cognitive Therapy (Mbct): Empirical Evidence and Clinical Applications from a Clinical Perspective.”

<sup>223</sup> Ibid., 79.

<sup>224</sup> Knabb, “Centering Prayer as an Alternative to Mindfulness-Based Cognitive Therapy for Depression Relapse Prevention.”



rather than an intrinsic personality issue.<sup>225</sup> This does not excuse poor choices as White posits the client has the autonomy to make a moral choice and accept the consequent responsibility for that choice.<sup>226</sup>

Finally, ACT places an emphasis on mindfulness, acceptance, metacognition, emotion, dialects, and the therapeutic relationship.<sup>227</sup> ACT posits the cause of psychopathology is the rigid fusion between cognition, emotion, and behavior. Clinical applications of ACT are easily adapted to a Christian perspective because Hayes, the founder of ACT, comes from a Catholic background and has expressed full support and desire for greater faith integration with ACT.<sup>228</sup>

### Burnout Prevention Strategies

Burnout is defined by Schaufeli & Greenglass as, a state of physical, emotional, and mental exhaustion that is produced after long-term involvement in stressful work situations that are emotionally demanding.<sup>229</sup> Research cited throughout this study has addressed the emotional and mental exhaustion that often accompany ministry work. Depression, somatization, and anxiety disorders were found to be common consequences of burnout.<sup>230</sup> MBSR, which is a “skillful blend of sitting and walking meditation, didactic presentations, gentle Hatha yoga, body

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<sup>225</sup> Kwok, “Narrative Therapy, Theology, and Relational Openness.”

<sup>226</sup> White and Epston, *Narrative Means to Therapeutic Ends*.

<sup>227</sup> Kai G. Kahl, Lotta Winter, and Ulrich Schweiger, “The third wave of cognitive behavioral therapies,” *Current Opinion in Psychiatry* 25, no. 6 (December): 522-28, <http://dx.doi.org/10.1097/yco.0b013e328358e531>.

<sup>228</sup> Joshua J. Knabb, *Faith-Based ACT for Christian Clients* (New York, NY: Routledge, Taylor & Francis Group, 2016).

<sup>229</sup> Wilmar B. Schaufeli and Esther R. Greenglass, “Introduction to special issue on burnout and health,” *Psychology & Health* 16, no. 5 (October): 501-10, <http://dx.doi.org/10.1080/08870440108405523>.

<sup>230</sup> Ibid.

scans, and group discussions,” has been found as an effective treatment approach for burnout.<sup>231</sup> Focus on the person, their experiences, their place in the Christian story and why they want to continue is the basis for resiliency training, which was also found to be an effective treatment for burnout.

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<sup>231</sup> Davis, “Preventing Clergy Burnout,” 26.

## CHAPTER FIVE: DISCUSSION

This chapter will begin with a brief summary of the study, including an overview of its purpose and procedure. Next, a brief discussion of research findings will be included, along with a discussion of the relationship between the findings and prior research. Limitations of the study will then be acknowledged and described. This chapter will offer implications for worship leaders with depression as well as possible forms of support by fellow staff members. Finally, the chapter will conclude with possible suggestions for future research.

### Summary of the Study

Although many worship leaders have a desire to lead their congregation in worship with joy and authenticity each week, struggles with depression may actually inhibit that from happening effectively.<sup>232</sup> While one may find substantial research regarding pastors who struggle with depression, there is diminutive research on worship leaders who struggle with depression. While it is true that worship leaders are staff members of the church, they too are members of the flock and need to be shepherded by the Pastor, yet Blanton and Morris note, “Many pastors are not trained to identify the symptoms of depression and anxiety, which will limit his or her ability to provide needed support.”<sup>233</sup> As more pastors become aware of the prevalence of depression, the need for treatment, and effective interventions, they will likely share that information with the congregation to demystify the stigma associated with mental health issues. In this study, sources were gathered, examined, and analyzed in order to identify the unique challenges faced

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<sup>232</sup> Noel Due and Kirsten Due, “Courage and Comfort for Pastors in Need,” *Lutheran Theological Journal* 52, no. 3 (December 2018): 128-40.

<sup>233</sup> Priscilla W. Blanton and M. Lane Morris, “Work-Related Predictors of Physical Symptomatology and Emotional Well-Being among Clergy and Spouses,” *Review of Religious Research* 40, no. 4 (jun. 1999): 331-48, <https://www.jstor.org/stable/3512120>.

by worship leaders with depression. Also, recent sources were studied to identify ways in which church staff can support worship leaders with depression.

### **Summary of Findings**

The purpose of this study was to raise awareness of both the etiology and symptomology of depression and anxiety as well as identify effective forms of support and interventions for the depressed worship leader according to current literature regarding worship leaders with depression. Although there is limited research specific to worship leaders with depression, current research on pastors with depression, and even fellow Christians with depression can be logically extended to worship leaders with depression.

Although there are many different factors that can lead to depression in worship leaders, research revealed several common themes found in the personal accounts of Brian Johnson, Matt Rogers, and Robert Griggs. One common theme reported by pastors with depression was incongruence as pastors attempted to treat their symptoms without disclosing their struggles to anyone else.<sup>234</sup> Just as many pastors feel the need to hide their struggles with depression, a second common theme found in the literature was the need for performance with many pastors settling for being loved for what they do rather than who they are.<sup>235</sup> The third common theme found in the research is isolation. Both Rogers and Johnson shared ways in which they isolated themselves from others. The pressure on pastors to fulfill the many expectations placed on them was an additional common theme found in the research. The final common theme that emerged among pastors with depression was failure to establish clear boundaries with many pastors

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<sup>234</sup> Lovejoy, *A Pastor's Guide for the Shadow of Depression*, 9.

<sup>235</sup> Ibid.

blurring, or even erasing completely, the boundary between church and self, resulting in their ministry becoming an extension of their own psyche.<sup>236</sup>

This study also indicated considerable differences in thought on the etiology and effective treatment options for pastors with depression. Research found that more fundamental denominations were more likely to perceive mental health issues as the result of *lack of faith*, or *sin*, in the believer,<sup>237</sup> while mainline Protestants and Catholics were more likely to accept the biological factors that contribute to mental health issues.<sup>238</sup> With such differences regarding the etiological considerations of mental health issues, it is no surprise that there are also considerable differences regarding effective treatment options for mental health issues. Webb found that Roman Catholics had less skepticism towards secular interventions for mental health issues,<sup>239</sup> while Trice and Bjorck found Pentecostals to consider spiritual discipline and faith as the most effective interventions.<sup>240</sup> Stanford and McAlister found that as many as 41 percent of individuals with mental health conditions were dismissed by their pastors, told that secular interventions would be ineffective, and encouraged to discontinue pharmacological treatment.<sup>241</sup>

This study found several effective non-pharmacological treatment options for Christians with depression. CBT is an empirically supported effective treatment for depression with the goal of helping the client learn the relationships between thoughts, emotions, and behaviors in

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<sup>236</sup> Griggs, *A Pelican in the Wilderness: Depression, Psalms, Ministry, and Movies*.

<sup>237</sup> Hartog & Gow, "Religious Attributions Pertaining to the Causes and Cures of Mental Illness."

<sup>238</sup> Payne; Webb, "Toward a Theology of Mental Illness."

<sup>239</sup> Webb, "Toward a Theolog of Mental Illness."

<sup>240</sup> Trice & Bjorck, "Pentecostal Perspectives on Causes and Cures of Depression."

<sup>241</sup> Stanford & McAlister, "Perceptions of Serious Mental Illness in the Local Church."

order to reduce depressive symptoms.<sup>242</sup> RCBT is similar to CBT with the exception that participants' religious beliefs and practices are used in the process of confronting irrational, or untrue, thoughts and replacing those false thoughts with biblical Truth;<sup>243</sup> however, Tulbure *et al* found no significant difference in the efficacy of CBT and RCBT.<sup>244</sup> Mindfulness based techniques such as MBCT and Centering Prayer were also found to be effective interventions for depression while easily adapted to a Christian perspective.<sup>245</sup> ACT posits the rigid fusion between cognition, emotion, and behavior is the cause of psychopathology and utilizes interventions which encourage the client to open up, be present, and do what matters.<sup>246</sup>

### **Limitations of the Study**

This researcher acknowledges certain limitations of this study. When conclusions are being drawn regarding the research, the following limitations should be considered:

1. There is limited research regarding worship leaders with depression; therefore, research on pastors with depression was extended to worship leaders with depression. Although there are many similarities between the demands and responsibilities of worship leaders and pastors, there are also differences which were not considered in this study.

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<sup>242</sup> Michelle J. Pearce *et al.*, "Effects of Religious Versus Conventional Cognitive-Behavioral Therapy on Gratitude in Major Depression and Chronic Medical Illness: A Randomized Clinical Trial," *Journal of Spirituality in Mental Health* 18, no. 2 (April): 124-44, <http://dx.doi.org/10.1080/19349637.2015.1100971>.

<sup>243</sup> Ibid.

<sup>244</sup> Bogdan Tudor Tulbure *et al.*, "Religious versus Conventional Internet-based Cognitive Behavioral Therapy for Depression," *Journal of Religion and Health* 57, no. 5 (November): 1634-48, <http://dx.doi.org/10.1007/s10943-017-0503-0>.

<sup>245</sup> Knabb, *Faith-Based ACT for Christian Clients*.

<sup>246</sup> Russ Harris, *ACT Made Simple: An Easy-to-read Primer On Acceptance and Commitment Therapy* (Oakland, CA: New Harbinger Publications, 2009).

2. Although the interventions included in this study were empirically supported and specific to Christians with depression, they were not specific to pastors or worship leaders with depression.
3. Documented cases of personal accounts of pastors with depression were considered in this study; however, only three accounts were included. Their experiences were unique to their situation and by no means represent all pastors with depression. Their accounts provide a first-hand account of a pastor with depression, but should not be used to make implications about other pastors with depression.

### **Implications for Practice**

Worship leaders face not only the same types of challenges faced by the congregation, but also face unique challenges. Each week, worship leaders stand before the congregation and proclaim the goodness and faithfulness of God as they lead others in praise and worship. When the worship leader has depression, he or she may not feel comfortable disclosing this to others including fellow staff members, members of the worship team, or the congregation for fear that they may be viewed as lack of faith, or ultimately a threat to their ministry.<sup>247</sup>

Misunderstandings of the etiology and symptomology of depression have fed the stigma of Christians who suffer from MDD. Misconceptions about the etiology of depression appear most common in fundamentalist denominations where depression is viewed by many as the result of sin or lack of faith.<sup>248</sup> Although research conducted by Trice and Bjorck found that many Pentecostals preparing for full-time ministry endorsed a number of potential non-spiritual causal factors for depression, many indicated that spiritual discipline and faith were the most

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<sup>247</sup> Lovejoy, *A Pastor's Guide for the Shadow of Depression*.

<sup>248</sup> Hartog and Gow, "Religious Attributions Pertaining to the Causes and Cures of Mental Illness."

effective treatment options.<sup>249</sup> As a result of these misunderstandings, worship leaders with depression may further isolate themselves instead of utilizing the church as a support system as they seek treatment, which has been found to increase the efficacy of treatment.<sup>250</sup>

For worship leaders who seek treatment, many options are rooted in Eastern Religions such as Buddhism and may not align with Christian values.<sup>251</sup> Many interventions such as CBT, ACT, and EFT have been adapted to Christian clients by maintaining the basic principles of each intervention while applying techniques which are in accordance to the Christian faith.<sup>252</sup> While some have noted benefits from other techniques such as Centering Prayer, those results have not been empirically validated.

### **Recommendations for Future Study**

The following recommendations for future study are made based on the findings and limitations of this study:

1. Qualitative and quantitative studies on worship leaders with depression. Both quantitative and qualitative studies specifically on worship leaders with depression could provide valuable insight into the unique challenges faced by worship leaders with depression. Although current research on pastors with depression can be logically extended to worship leaders with depression, there are unique roles and responsibilities of worship leaders which is likely not addressed in current research.

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<sup>249</sup> Trice and Bjorck, "Pentecostal Perspectives on Causes and Cures of Depression."

<sup>250</sup> Sreevani, "Effectiveness of Integrated Body-Mind-Spirit Group Intervention on the Well-Being of Indian Patients with Depression."

<sup>251</sup> Rosales and Tan, "Mindfulness-Based Cognitive Therapy (Mbct): Empirical Evidence and Clinical Applications from a Christian Perspective."

<sup>252</sup> Ibid., Rosales and Tan.



2. Psychoeducational programs for churches. Much of the stigma surrounding Christians with mental health issues is due to lack of understanding of the etiology of mental health issues. Although studies have identified these misconceptions, few recommendations have been made to clarify these misunderstandings. This may be achieved through psychoeducational programs.
3. Studies to identify effective ways to detect early signs of depression in ministers. Many of the early signs of depression go unnoticed by fellow staff members until a major mental health crisis occurs. Early intervention strategies may prevent such crisis from occurring. These findings could be life-saving in some instances.
4. Evaluation of current biblical/Christian interventions for depression. There are resources available which offer Christian interventions for depression from a biblical perspective; however, many of these resources have not been evaluated for reliability and validity. A comprehensive study of these interventions could provide empirical support which may lead to more wide-spread acceptance and implementation by both Christian and secular therapists.

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