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ABSTRACT

**DEPRESSIVE SYMPTOMATOLOGY AMONG HISPANIC
MINISTERS OF THE NORTH AMERICAN DIVISION OF
SEVENTH-DAY ADVENTISTS**

by

Enrique Nicolás Calandra

Adviser: Alfonso Valenzuela

ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University

Seventh-day Adventist Theological Seminary

**Title: DEPRESSIVE SYMPTOMATOLOGY AMONG HISPANIC MINISTERS
OF THE NORTH AMERICAN DIVISION OF THE SEVENTH-DAY
ADVENTISTS**

Name of the researcher: Enrique Nicolás Calandra

Name and degree of faculty adviser: Alfonso Valenzuela, Ph.D.

Date completed: May 1999

The intensity of our work and living and the struggles we all experience have led to a dramatic increase in the incidence and severity of stress-related disorders, including depression. Ministers—as human beings and helping professionals—are not exempt from this reality. In fact, several studies have shown they are especially vulnerable to it. Although this is a sensitive issue, it needs to be discussed more openly, acknowledging its existence and taking steps to find causes and solutions.

This dissertation seeks to (1) measure and analyze the existence and the intensity

of depressive symptomatology among Hispanic pastors of the North American Division of Seventh-day Adventists; (2) probe nine major areas that may be related to depression in this group; and (3) identify the support systems these ministers draw from to help them prevent or cope with this illness.

To achieve these objectives, two questionnaires were mailed to the 400 Hispanic pastors working with Hispanic churches in the selected territory: (1) a cross-cultural scale for the quantitative measurement of depressive symptomatology in adults; and (2) a survey designed to assess marital and family issues, work-related issues, spiritual issues and devotional life, educational background and intellectual development, lifestyle and health, emotional health, social life and support systems, financial issues, and stressful life events.

The analysis of these instruments showed that a considerable percentage of the survey population presents levels of depressive symptomatology above the normal range, indicating different degrees of depression. It also established statistically significant correlations with most of the areas studied, demonstrating the complexity of this illness, which is usually related to a combination of many factors. Specific areas of strength and concern were pointed out and several recommendations were given.

A balanced lifestyle—involving the spiritual, mental, physical, and social aspects of life—was recommended not only as the most effective antidepressant, but also as the best healing alternative. Suggestions on resources that can help ministers achieve this balance were also offered.

Andrews University
Seventh-day Adventist Theological Seminary

**DEPRESSIVE SYMPTOMATOLOGY AMONG HISPANIC
MINISTERS OF THE NORTH AMERICAN DIVISION OF
SEVENTH-DAY ADVENTISTS**

A Dissertation
Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Ministry

by
Enrique Nicolás Calandra

May 1999

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To Viviana, my wife, friend, and life's companion
who encourages and supports my work tirelessly;
and to our sons Giovanni and Julio
who have made our lives fuller and help us
to understand better God's infinite love

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Above all, I would like to express my gratitude to God, who has led me and my family in many providential ways, giving us the strength to attain our goal of enhancing our preparation to serve Him better. To Him be our love, worship, and praise!

CHAPTER I

INTRODUCTION

Statement of the Problem

Our speeded-up world, the intensity of our work and living, and the struggles, expectations, crises, and losses we all experience have led to a dramatic increase in the incidence and severity of stress-related disorders, including depression.

Some of our current cultural values and priorities contribute to this increase in depression, among them the implicit or underlying conception that we need to prove our worth. This is completely opposed to the Christian gospel and its teachings. These cultural values have inflicted great damage on the emotional health of our society members by overemphasizing performance, competition, extroversion, intelligence—measured in specific and arbitrary terms—and other “ideals” that lead many to struggle with feelings of failure, inadequacy, and low self-esteem.

As it was so insightfully expressed, “We live in a hostile environment of competition. We are under pressure to compete to stay afloat, and when we do, we often find ourselves hopeless in the competition. The stress that results from this is many times the front door to depression.”¹

¹William Hulme and Lucy Hulme, *Wrestling with Depression* (Minneapolis, MN: Augsburg, 1995), 87, 90.

And competition invariably leads to comparisons. Each of us seems to be confronted with the pressure of achieving success. Most people experience anguish as they think they may fail to achieve higher positions or that they may even fall off the ladder of success. The cultural values that underline this emphasis on making comparisons may be internalized in such a way that they become our own, and then, through this misleading vision, we can perceive others as better prepared, and more self-possessed than we are. This down-on-me attitude can be one of the early symptoms of depression.

Ministers—as human beings and helping professionals—are not exempt from these realities. In fact, several studies have shown that they are especially vulnerable to them.¹ Their roles and job descriptions put them in many unique and very demanding situations.

A placard once used in recruiting priests reads: “The great moments in a person’s life are: Birth, Confirmation, Communion, Marriage, and Death. Would you like to be the person most needed at such times?”² Although ministry in these crucial moments in a person’s life require special skills and great understanding, they are not the only events that emotionally exhaust the minister.

At various times, ministers are expected to have outstanding talents in every conceivable field of knowledge—administration, building, public speaking, diplomacy, psychology, economics, medicine, maintenance, teaching, counseling, and coordinating, among others. They are expected to fulfill everybody’s expectations, and work tirelessly

¹Archibald D. Hart, *Coping with Depression in the Ministry and Other Helping Professions* (Waco, TX: Word, 1984), 12.

²Quoted by G. Curtis Jones, *The Naked Shepherd* (Waco, TX: Word, 1979), 75.

—without showing signs of anger or discouragement—sixteen hours a day, seven days a week. They are also expected to maintain an irreproachable behavior, to have a perfect family, and to be all-wise, all-comforting, all-controlled, and ever-present. “Ministers are placed upon a pedestal—a position that allows little room for human weaknesses.”¹

The truth is, though, that pastors are not superhuman. They do, as any other human being, experience physiological, spiritual, sociological, and psychological needs.

As Lucille Lavender, a minister’s wife, said it so clearly:

God sent a *man* to minister. This man has the physical needs of all men. He gets tired, hungry. He has creative needs, sexual needs. He feels all emotions known to all men. He feels pain, discouragement, inadequacy, fear, doubt, jealousy, neglect, anger, and, at times, he feels unloved, lonely, and unappreciated. *He cries, too!*²

Many of the problems pastors experience are not caused by people—or the pastor himself—forgetting that he or she is a pastor. They arise when they forget he or she is a person—a normal human being, struggling with the same problems than everyone else, in addition to the specific problems related to their ministerial profession. Overwork, feelings of failure, physical or emotional pain, and loneliness, may lead pastors to experience shorter or longer periods of depression. Oftentimes, feelings of guilt, shame, mistrust of what others will think, fear of jeopardizing their jobs, or low self-esteem can worsen their depression, leading them to overwhelming anxiety and, in some extreme cases, even intents of suicide.

¹Benjamin D. Schoun, “The Minister as a Human Being,” in *The Adventist Minister*, ed. C. Raymond Holmes and Douglas Kilcher (Berrien Springs, MI: Andrews University Press, 1991), 2.

²Lucille Lavender, *They Cry, Too!* (New York, NY: Hawthorn, 1976), 35.

Statement of the Task

These realities, together with my pastoral experience, and my background of a MA in Community Counseling, have challenged me to study this matter further, discovering relevant data on the possible existence of depressive symptomatology among the Hispanic pastors of the North American Division of Seventh-day Adventists, and ways to make these realities better known in order to break down the silence and open the topic for discussion. This could be the first step toward helping pastors deal with this issue in a healthier and more positive way.

This dissertation, then, seeks to measure, describe, and analyze the possible existence of depressive symptomatology among the Hispanic pastors of the North American Division of Seventh-day Adventists.

Justification for the Dissertation

According to conservative estimations, depression affects more than 17 million Americans each year.¹ Furthermore, every person experiences repeated cycles of “normal” depression, and those denying its existence either do not know how to recognize the symptoms, or simply have labeled them in a different way.² However, a remarkable fact is that fewer than one-third of these millions ever receive treatment or are aware—or

¹National Institutes of Health’s Guide for Students, “What to Do If a Friend Has Depression”; available from <http://www.save.org/student.html>; accessed 7 October 1997, 1-4.

²Hart, 6.

willing to accept—that their misery could be relieved.¹ Over a course of a lifetime, up to 12 percent of men and 20 percent of women will suffer from *depressive illness*. Its episodes can last from a few months to many years, and it is highly recurrent. Eighty percent of patients who have had a depressive episode will have another one.²

We need to be aware that, in spite of the joyous experience of soul-winning and of nurturing and building God's church, depression is a major occupational hazard for ministers. Furthermore, specific issues, traits, and/or cultural values of the Hispanics may cause this ethnic group to be more prone to depression than others.³ But depression is a sensitive issue which is seldom discussed openly.

There is still a "stigma" connected to mental illnesses, including depression. It seems easier and more acceptable to suffer from pneumonia, heart problems, or cancer than to get the support, care, and understanding needed to cope with depression.

It is time we challenged the stupidity of this stigma. Perhaps if we called depression a brain disease, which in many respects it is, that would move it more toward the physical, and hence make it more acceptable. Because of the stigma, families have often tended to cover up for their depressed member—to "hide" him or her. Therefore the depressed person doesn't get to the needed help as soon as possible. The condition, consequently, grows worse.⁴

These and/or other factors may prevent ministers from acknowledging the

¹Peter C. Whybrow, *A Mood Apart—Depression, Mania, and Other Afflictions of the Self* (New York, NY: Basic Books, 1997), 7.

²Brian P. Quinn, *The Depression Sourcebook* (Los Angeles, CA: Lowell House, 1997), vii.

³Derald Wing Sue and David Sue, *Counseling the Culturally Different* (New York, NY: John Wiley, 1990), 230-237.

⁴Hulme and Hulme, 109.

existence of symptoms of depression in their own lives and from seeking early solutions. There is a need to be more open about this issue, acknowledging its existence, measuring its intensity, and taking steps toward finding possible causes as well as preventive measures and curative alternatives.

As church leaders, we need to talk to each other about these important issues. No one understands ministry better than us, since we are involved in it daily. We are, therefore, in the best position to understand, encourage, support, and challenge each other. Very often, though, we seem reluctant to do it. How ironic that we, who seek to help and comfort others every day, often bury our own burdens within our souls!

Of course, the support of friends and colleagues is no substitute for the inner peace and strength that comes from a healthy relationship with God. He is the ideal “friend who sticks closer than a brother” (Prov 18:24). Furthermore, companionship with others should not be a substitute for understanding the biblical teachings and how to apply them to one’s own life. As Kenneth L. Swetland, an experienced minister and theology professor, wrote:

We should not disregard Paul’s advice to the Galatian believers: “Each one should carry his own load” (6:5). But in the preceding phrases Paul also challenged these Christians to “carry each other’s burdens, and in this way you will fulfill the law of Christ” (6:2). The “burden” of verse 2 is the crushing weight that is too much for one person to bear, and the “load” of verse 5 is the “back-pack” each Christian should carry on his or her own.¹

It takes God-given wisdom to see the difference between the two, but that insight may well make the difference in our ministry and our relationship with Christ. Our

¹Kenneth L. Swetland, *The Hidden World of the Pastor* (Grand Rapids, MI: Baker, 1995), 12.

ministry sometimes fails because we would rather do it alone than seek counsel from someone else. We would rather help than be helped, and while this is not bad in itself, it can become a real problem when our ministry falters because we do not pay attention to matters that need to be addressed in our own lives.

To the best of my knowledge, there are no previous published studies about depressive symptomatology among SDA Hispanic ministers within the North American Division of Seventh-day Adventists. It is hoped this study will fill this void.

Definition of Terms

Depression: Refers to words with different meanings. Most people use the term to refer to feelings of sadness, or a temporary mood resulting from a loss, disappointment, or failure. It is also used to label a wide range of other symptoms such as irritability, changes in sleep, appetite, and weight. These symptoms, though, can have many causes other than depression in the *psychiatric* sense.

Depression as an illness . . . is much more than a feeling of sadness. It is a serious medical condition, which adversely affects not only a person's feelings but also his or her health, productivity, relationships, and ability to think clearly and rationally. . . . Severe depressions can be incapacitating and life threatening.¹

The *emotion* or *mood* of depression, which is short lived, comes and goes caused by transient circumstances. We could refer to it as "normal" depression. On the other hand, the *disease* of depression persists and deepens over several weeks or months. "It is a

¹Quinn, vii.

syndrome, a set of symptoms or diagnostic signs that tend to appear together.”¹ It is a medical disorder as real and as serious as diabetes or cancer, and it affects the body as well as the mind, trapping its victims in a prolonged and bleak state of hopelessness and helplessness. Mental health professionals use the word depression to refer to an illness or group of illnesses called *mood disorders*. It is in its psychiatric sense that the term is mainly used in this dissertation.

Mood disorders: Refers to a group of disorders that affect a person’s thoughts and feelings with episodes of depression and/or mania. They are divided into *depressive or unipolar disorders* (one or more depressive episodes), *bipolar disorders* (one or more manic episodes alternating with depressive episodes), *mood disorder due to a general medical condition*, and *substance-induced mood disorder*. Someone with a unipolar disorder suffers only from depression. It can be a major depression, dysthymia (chronic, mild depression), or depressive disorder not otherwise specified. People suffering from bipolar disorders swing wildly from frantic highs to numbing lows. The highs are called manic episodes, and the lows depression. Bipolar disorders include manic-depressive illness (also known a bipolar I disorder), bipolar II disorder, cyclothymia, and bipolar disorder not otherwise specified.²

In chapter 3, I define these terms further, differentiating them also from two other terms with which depression is sometimes confused—stress and burnout.

¹William R. Miller and Kathleen A. Jackson, *Practical Psychology for Pastors* (Englewood Cliffs, NJ: Prentice Hall, 1995), 198.

²American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (Washington, DC: American Psychiatric Association, 1997), 317-391.

Depressive symptomatology: Although this term is covered in more detail later on, I would like to list here the key signs of depression that were tested in this research. They include a depressed mood, loss of interest or pleasure in usual activities, change in appetite, change in sleep patterns, change in movement, fatigue, feelings of worthlessness, self-reproach, or guilt, change in thinking and concentration, and suicidal thoughts and acts.¹ Although the encountering of any set of key indicators should set off a signal of the possible presence of depression, the current psychiatric convention has established that a major depression should be diagnosed when there are “at least 2 weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression.”²

North American Division of Seventh-day Adventists: A division is the largest geographical and administrative unit of the General Conference of Seventh-day Adventists (SDA). The North American Division is composed of the land areas of two countries: the United States of America and Canada. It includes the SDA Church in Canada, and the Atlantic, Columbia, Lake, Mid-America, North Pacific, Pacific, Southern, and Southwestern Union Conferences. These unions, in turn, are subdivided into local conferences which contain the local churches.

Methodology of the Project

This is a descriptive research based on the responses of Hispanic SDA pastors working within the North American Division. The study was conducted as follows:

¹Ibid.

²Ibid., 317.

1. A review of selected religious, sociological, and psychological literature dealing with depression—history, types, symptoms, causes, treatments—was undertaken. This included biblical references, and Ellen G. White’s contributions to the topic.

2. Two questionnaires were mailed to the 405 Hispanic pastors working with Hispanic churches in the North American Division territory. The first was a cross-cultural, confidential survey for the quantitative measurement of depressive symptomatology in adults—the Zung SDS Scale.¹ The second was developed following the models introduced by Benjamin Schoun; Roy M. Oswald, as presented by Schoun; Lee and Balswick, as adapted by Valenzuela; and Miller and Jackson.² The wording and format were similar to the surveys they used, although some additional questions—relevant to the specific topic of this research—were added. The main purpose of this second questionnaire was to probe major areas of stress and possible factors related to depression in this group. It also tried to identify the support systems these ministers draw from—or would be willing to draw from—to help them cope with this illness.

3. The results from these questionnaires were analyzed and interpreted using the descriptive and comparative research methods. In the case of the Zung SDS Scale,

¹William W. K. Zung, “A Cross-Cultural Survey of Symptoms in Depression,” *American Journal of Psychiatry* 126 (1969): 116-121. For the Spanish version see: V. Conde, J. A. Escriba, and J. A. Izquierdo, “Statistic Evaluation and Spanish Adaptation of Zung’s Self-Applied Scale for Depression,” *Archives of Neurobiology* 33 (1970): 281-302.

² These surveys can be found in: Alfonso Valenzuela, “An Ecosystemic Analysis of Marital Satisfaction in Seventh-day Adventist Clergy Families” (Ph.D. dissertation, Fuller Theological Seminary, 1991), 86, 87, 166-169; Benjamin D. Schoun, *Helping Pastors Cope* (Berrien Springs, MI: Andrews University Press, 1981), 204-226; and Miller and Jackson, 460-461.

participants were ranked as within normal range, or showing the presence of minimal to mild, moderate to marked, or severe to extreme depressive symptomatology. The participants were offered the alternative of receiving a confidential evaluation of their personal results. Regarding the second questionnaire, the different factors were considered independently, and statistically significant correlations between them and the results of the SDS scale were analyzed and discussed. This questionnaire studied marital and family issues, work-related issues, spiritual issues and devotional life, educational background and intellectual development, lifestyle and health, emotional health, social life and support systems, financial issues, and stressful life events. This list of issues is by no means expected to be exhaustive, rather it is intended as an explorative identification of major areas that may contribute to depression in the ministerial profession.

4. Based on these findings, recommendations and conclusions were made. In order to develop awareness of the topic and suggest preventive and healing measures, three articles were written and sent to *Ministry*—the denomination’s publication for ministers—for publishing. See appendix E.

Organization of the Study

Chapter 1 provides an introduction to the study, and presents a general overview of the problem of depression in ministry. Chapter 2 reviews the literature investigating depression in history, its evolution up to the present, and its incidence and effects on specific groups such as Hispanics in the United States and ministers. It also presents what the Bible and Ellen G. White say about the topic.

Chapter 3 concentrates on defining, recognizing, and explaining depression. It presents current medical and psychological data to help us understand the problem better, and it also includes some myths and realities about depression. Chapter 4 reports on the two questionnaires mailed to the SDA Hispanic pastors throughout the North American Division, analyzing and interpreting the data collected.

Chapter 5 closes the project, presenting general conclusions of the research as well as recommendations on preventive measures, coping mechanisms, and curative alternatives. It also suggests areas for further study. All Bible references in this research, unless otherwise specified, have been taken from the New International Study Bible.

The appendices, in addition to models of the cover letters (Appendix A) and copies of the survey instruments both in Spanish and in English (Appendix B), include tables with information on statistical analysis (Appendix C), information on resources available to prevent and cope with depression (Appendix D), the articles submitted for publication (Appendix E), and an outline for a Seminar on Depression (Appendix F), which may be presented at different meetings or conventions to make the study better known and to serve as a helping tool.

Expectations and Limitations of the Dissertation

This project will create awareness of the existence of depressive symptomatology among the Hispanic ministers of the North American Division of Seventh-day Adventists, and it will contribute to the understanding of the problem of depression, striving to break down taboos and myths about the topic while presenting its realities.

It is hoped that the information provided will be a practical guide for all ministers, enhancing the knowledge of possible causes, coping mechanisms, and resources available, and suggesting preventive and curative alternatives. It is also hoped that it will stimulate a more open discussion among the Hispanic leaders of this Division, challenging them to pursue additional studies on this specific topic and the wider area of emotional health, and to implement all viable means to help alleviate this problem. In addition, the insights gained through this study will help all of us when dealing with depression among our church members.

This research was prepared to apply specifically to SDA Hispanic ministers in the North American Division. Although general literature provides evidence that similar principles might apply in other countries, other ethnic groups, or other denominational situations, they would need to be assessed separately. Further research comparing findings of this study to those of other ethnic groups, or across denominations, could prove to be very valuable.

It should also be noted that the medical and psychiatric fields have increased their knowledge of mood disorders extensively over the last few years, and much more is expected in the near future.¹ Thus, we must keep in mind that this is an ongoing topic and, in order to keep well informed and abreast of the latest discoveries and the best preventive and curative alternatives, frequent and periodical updates of our reference material are needed.

¹Quinn, 246-250.

Finally, this was an explorative descriptive research project, and although some likely factors contributing to depression are discussed and percentile norms and other statistical methods suggesting possible relationships are presented, this should not be seen as a causative study. We must specially bear in mind that even though a study such as this may give clues as to some areas that may contribute to depression, each individual is unique, and only the proper medical or psychiatric personnel would be qualified to diagnose depression and study in depth the factors that have led to and/or contributed to its existence as well as the best treatment to overcome it.

CHAPTER II

A REVIEW OF SELECTED LITERATURE ON DEPRESSION

Depression in History

Depression is one of the oldest human afflictions of which we have written records. Hippocrates, the ancient Greek healer who lived in the fifth century B.C., described patients who suffered from “melancholia,” a condition with the same symptoms as what we call major depression today, including the lack of energy, early morning awakening, inability to feel pleasure, the loss of appetite or weight, and excessive or inappropriate guilt.¹ Plutarch, in the second century A.D., described the melancholic as “a man who sits out of doors, wrapped in sackcloth, rolling in the dirt, confessing about this and that sin.”² In the sixteenth century, William Shakespeare described similar symptoms in one of his characters, Hamlet. Sinking into despair, Hamlet laments,

How weary, stale, flat and unprofitable
Seem to me all the uses of this world!³

¹Dianne Hales, *Depression* (New York, NY: Chelsea House, 1989), 13.

²Plutarch, quoted in Marvel E. Dianas, “How to Cope with Depression,” *Signs of the Times*, March 1985, 12.

³William Shakespeare, quoted in Carol Falvo Heffernan, *The Melancholy Muse* (Pittsburgh, PA: Duquesne University, 1995), 132-133.

Even more severe was the depression which tortured Abraham Lincoln throughout his entire life, and led him to write the following words,

I am now the most miserable man living. If what I feel were equally distributed to the whole human family, there would not be one cheerful face on earth. Whether I shall ever be better, I cannot tell; I awfully forebode I shall not. To remain as I am is impossible. I must die or be better, it appears to me.¹

Indeed, depression has been a part of human existence since ancient times, but as scientists discovered more about the human body and psyche, theories of the causes and treatments of the disorder evolved. “Speculations about the ailment have progressed from the ancients’ discussion of ‘humors’ to twentieth century breakthroughs that have traced some types of depression to chemical imbalances in the brain.”²

Other references to “melancholia” in ancient times came from the Greek philosopher Aristotle (384-322 B.C.), the Roman physician Rufus of Ephesus, who lived during the age of Trajan (A.D. 98-117), and the Greek physicians Galen (A.D. 129-ca. 199) and his contemporary Aretaeus (second century A.D.).³

The middle ages were not exempt of physicians referring to “melancholia,” among them Alexander of Tralles (ca. 525-605), who practiced in Rome, and the Islamic physician Ishaq ibn Imran, who lived in the early tenth century.⁴ In 1621, during the

¹Abraham Lincoln, quoted in Dwight L. Carlson, *Why Do Christians Shoot Their Wounded?* (Downers Grove, IL: InterVarsity, 1994), 24.

²Hales, 23.

³Stanley W. Jackson, *Melancholia and Depression from Hippocratic Times to Modern Times* (New Haven, CT: Yale University, 1986), 29-45.

⁴*Ibid.*, 46-49.

renaissance period, the British clergyman and author Robert Burton (1557-1640) published a survey of ideas about melancholia called *The Anatomy of Melancholy*.¹ “This remarkable book urges patients to employ a treatment that combines prayer, medication, diet, and the solace of talking with friends. Burton concludes his treatise by advising all victims of melancholia to ‘be not solitary, be not idle’.”²

Until the seventeenth century, most theorists thought depression was the result of an excess of black bile. Dr. Archibald D. Hart, former Dean of the Graduate School of Psychology at Fuller Theological Seminary, describes how in the seventeenth century new concepts of melancholia were introduced as a result of progress in the knowledge of chemistry, anatomy, and the general understanding of emotional disorders.³ The theory of the black bile was rejected in favor of other biological possibilities, such as the notion that the disorder was caused by problems in the vascular or neurological systems.⁴ By the eighteenth century the relationship of emotion to the somatic or bodily system was becoming clearer, and theories and concepts were rapidly evolving, brought about by physicians and clergymen such as Richard Napier (1559-1634), Archibald Pitcairn (1652-1713), and Friedrich Hoffmann (1660-1742).⁵

¹Robert Burton, *The Anatomy of Melancholy*, 3 vols. (London: G. Bell & Sons, 1893).

²Hales, 27.

³Hart, 3.

⁴Ibid., 3-4

⁵Jackson, 104-110, 116-119.

The nineteenth and early twentieth centuries saw the beginnings of the theory that depression is a psychological disorder, and the fact that depression could occur either as an isolated illness or as a periodic problem (sometimes alternating with times of manic excitement) was generally accepted.¹ Among the most important exponents of this period were the Americans Benjamin Rush (1745-1813), and Adolf Meyer (1866-1950), the French Jean-Étienne-Dominique Esquirol (1772-1840), the Germans Richard von Krafft-Ebing (1840-1902) and Emil Kraepelin (1856-1926), and the Viennese psychiatrist Sigmund Freud (1856-1939).² Freud believed that depression was strictly the result of psychological factors—a conflict between the forces of the superego and those of the ego. This view, although accepted by many, has been strongly criticized by others, especially in more recent years.³

Several systematic studies shed further understanding onto the complexity of this illness during this century, such as the ones done by Kraepelin (1913) of 899 cases of manic-depressive psychosis; Paskind (1929-1930) of 633 cases of depression seen in private practice; and Lundquist (1945) of 319 manic-depressive illness (123 men—38%, and 196 women —62%) over a period of twenty to thirty years, just to name a few.⁴

¹Hales, 36.

²Jackson, 147-248.

³Hales, 35.

⁴Aaron T. Beck, *Depression: Causes and Treatment* (Philadelphia, PA: University of Pennsylvania Press, 1987), 46-48.

Modern research indicates that depression and manic-depressive illness are complex disorders that involve biological, psychological, spiritual, and social factors. According to Aaron T. Beck, M.D., professor of Psychiatry at the University of Pennsylvania School of Medicine, and Chief of Section at the Department of Psychiatry at the Philadelphia General Hospital,

Although depression (or melancholia) has been recognized as a clinical syndrome for over 2,000 years, as yet no completely satisfactory explanation of its puzzling and paradoxical features has been found. There are still major unresolved issues regarding its nature, its classification, and its etiology.¹

But even though today scientists still disagree about these and other areas of the illness, the importance of depression is recognized by everyone in the field of mental health. Dr. Beck believes that “more human suffering has resulted from depression than from any other single disease affecting mankind.”²

Depression in Our Age

Today, the pain of depression remains just as intense and as widespread. Depressive illness is common, painful, and dangerous—and it still is on the rise. As mentioned in the introduction, depression affects more than 17 million Americans each year,³ and according to the American Psychiatric Association about one of every five Americans experiences an episode of *depressive illness* in his or her lifetime.⁴ These

¹Ibid., 3.

²Ibid., 4.

³National Institutes of Health’s Guide for Students, 1.

⁴American Psychiatric Association, quoted in Quinn, vii.

episodes can last from several months to many years, and they are highly recurrent.

Eighty percent of patients who have had a depressive episode will have another one.¹

Depressive illness also has a great impact on the productivity and health of Americans. “It is the second leading cause of lost days at work, and a study found that it costs employers about \$33 billion a year in absenteeism and lost productivity.”² Moreover, the median age for depression, and for its most drastic consequence—suicide—has fallen.

Many psychological and sociological commentators . . . emphasize there is now very clear evidence that the “age of anxiety” that characterized the first half of this century has given way to an “age of melancholia”—that depression is the dominant mood of our age. Mental health statistics appear to support this interpretation. The suicide rate has increased dramatically over the past twenty years . . . and the median age for suicide is now just under thirty—and dropping. This is a significant change since before World War I, when the median suicide age was between forty and fifty.³

With regard to the lethality of depression, “between 10 and 30 percent of depressive and manic-depressives kill themselves.”⁴ In fact, suicide is the eighth leading cause of death in adults (and could be higher since many accidents are suspected to be suicidal acts in disguise), and the second leading cause of death in children and adolescents.⁵ The majority of adolescents who commit suicide suffer from some form of

¹Ibid.

²Ibid., viii.

³Hart, 4-5.

⁴Donald F. Klein and Paul H. Wender, *Understanding Depression* (New York, NY: Oxford University Press, 1993), 3.

⁵Ibid., 5.

mood disorder. Indeed, depression is growing among children and adolescents.¹ A study conducted by Seligman,² shows that young people today are ten times more likely to suffer major depression than their grandparents were fifty years ago, and the American Psychiatric Association estimates that 3 to 6 million young people may currently be depressed.³ Another study, conducted by Lopez,⁴ shows that an estimated 25 percent of college students suffer from depression at one time, and 33 percent of college dropouts suffer from depression before leaving school. Depression can and does appear at any age, and it does not respect sex, occupation, education, or ethnic background either. In fact, it is so common that it is often referred to as the common cold of mental health problems.⁵

Several studies conducted to determine the lifetime prevalence of depression,⁶ that is, the percentage of people in the population who have had the disorder at least once in their lifetime, showed that people with both a known genetic risk for the disorder and

¹Quinn, viii.

²Martin E. P. Seligman, "Research in Clinical Psychology: Why Is There So Much Depression Today?" *G. Stanley Hall Lecture Series* 9 (1988): 79-96.

³American Psychiatric Association, quoted in Hales, 14.

⁴Frederick G. Lopez, "Family Structure and Depression: Implications for the Counseling of College Students," *Journal of Counseling and Development* 64 (April 1986): 508-511.

⁵See Gary R. Collins, *Christian Counseling* (Dallas, TX: Word, 1988), 105; Quinn, 4.

⁶Such studies as: L. N. Robins et al., "Lifetime Prevalence of Specific Psychiatric Disorders in Three Sites," *Archives of General Psychiatry* 41 (1984): 949-958; and G. L. Klerman et al., "Birth Cohort Trends in Rates of Major Depressive Disorder among Relatives of Patients with Affective Disorder," *Archives of General Psychiatry* 42 (1985): 689-693.

those with no known risk showed about the same percentage increase in lifetime prevalence over the last thirty to forty years, indicating that “some environmental effect must be operating to account for the increase.”¹

According to Dr. Quinn, social stresses unique to modern culture such as the increased divorce rate, increased numbers of children born out of wedlock, and the breakdown of social ties in our highly mobile society may be some of the causes behind this alarming increase. In addition, biological stresses such as increased drug abuse, industrial toxins, dietary imbalances, alterations in daily and seasonal rhythms of sleep, and decreased exposure to sunlight due to indoor work may also be accountable for it.² Chapter 3 presents these and other causes which may lead to depression.

Although new treatments for depression have been developed—some of which are yielding excellent results—there is still a great number of people in the United States suffering from untreated depressive illness. According to the American Psychiatric Association, less than 33 percent of depressed people seek help.³ Therefore, the importance of an early diagnosis and treatment to avoid its recurrence and more serious consequences cannot be overemphasized.

¹Richard R. Bootzin, Joan Ross Acocella, and Lauren B. Alloy, *Abnormal Psychology* (New York, NY: McGraw-Hill, 1993), 244.

²Quinn, viii.

³American Psychiatric Association, quoted in Quinn, ix.

Depression among Hispanics in the United States

Since the sample population of this research is composed of Hispanic pastors, it is important to look at the general data available on Hispanics in the United States, as well as specific data on previous studies on depression among them to see how these studies compare with those of the general population and to find out what factors could influence positively or negatively the incidence of depression among this particular ethnic group.

Use of the Term “Hispanic”

In this research the term “Hispanic” is used to indicate individuals living in the United States and/or Canada whose common background is the Spanish language. Although Hispanics share some common characteristics, to better understand this very heterogeneous group we must keep in mind that there are distinct differences between and within the different groups and/or countries Hispanics represent. These differences range from physical characteristics to customs, values, cultural backgrounds, and lifestyles.

General Data on Hispanics in the United States

According to the *Statistical Abstract of the United States*, Hispanic Americans comprised a population of 28.3 million in 1996, of whom nearly 18 million are of Mexican descent, almost 3 million are from Puerto Rico, and just over 1 million are from Cuba. The rest are from other Spanish-speaking countries.¹ However, the same source estimates that there are probably around 4 million undocumented Hispanic immigrants in the United

¹U.S. Department of Commerce, *Statistical Abstract of the United States* (Washington, DC: Bureau of the Census, 1997), 12-65.

States, which brings the actual number of Hispanics currently residing in the United States to around 32 million.¹ Because of the high birthrate and ongoing immigration patterns, it is projected that Hispanics will be the largest minority group in the United States by the year 2010. But if we take into account the undocumented residents, Hispanics may already be the largest minority group.²

Hispanic Americans are a very young population, with an average age almost ten years younger than White Americans and two years younger than Black Americans.³ Because of their strong emphasis on large families and youth, nearly twice as many Hispanic households (54%) are comprised of four or more people as compared to 28 percent for the country as a whole.⁴

The vast majority of Hispanic Americans live in metropolitan areas of the United States and populate every state, including Alaska and Hawaii. In certain states and cities, they make up a substantial percentage of the population such as the states of California, Texas, Florida, Arizona, and New Mexico, and the cities of New York, Chicago, Miami, and Los Angeles.⁵

¹Ibid.

²Ibid.

³P. Odin, "Hispanics Help Shape the Educational Landscape," *Black Issues in Higher Education* 4 (1987): 1, 7, 11.

⁴G. J. Church et al., "Hispanics: A Melding of Cultures," *Time*, July 8, 1985, 36-39.

⁵Frank L. Schick and Renee Schick, eds., *Statistical Handbook on U.S. Hispanics* (Phoenix, AR: Oryx, 1991), 8.

According to the 1997 *Statistical Abstract*, in 1996 the median family income for Hispanics was \$24,570 compared to \$25,970 for Blacks and \$42,646 for Caucasians.¹ With regard to education, Hispanic students have not been faring very well either. Nearly half of the Hispanic students drop out before completing high school. This is more than double the rate for Blacks and three times higher than that for White students.² It would appear that many of these educational difficulties could be related to their limitations in the use of the English language.³

General Values, Traits, and/or Stressors of the Hispanic Population in North America

This in itself could be the topic of more than one research study, therefore, far from presuming to approach this subject in a comprehensive way, this study merely tries to mention a few values, traits, and/or stressors which may have some influence on the emotional health in general—and depression in particular—of the Hispanic population in North America.

A common value shared by most Hispanics is the importance they give to family traditions. “Family unity is seen as very important, as is respect for and loyalty to the family.”⁴ Furthermore, within the family circle the emphasis is on cooperation rather than competition, and children are expected to be obedient. Usually they are not consulted on

¹U.S. Department of Commerce, 12-65.

²Odin, 7.

³Sue and Sue, 229.

⁴Ibid., 230.

family decisions which may lead Hispanic kids to be less prepared to be assertive and to succeed in the highly competitive world they confront outside.¹

Interpersonal relationships are strongly emphasized among the Hispanics. They are maintained and nurtured within a large network of extended family and friends, and these are generally seen as the main resource of support and help.² Actually, advice from others is generally not sought until it is obtained from the extended family and close friends.³ Although this can be an advantage, some authors point out that “along with the many positive features, emotional involvement and obligations with a large number of family and friends may also function as an additional source of stress.”⁴

In general, children are expected to contribute financially to the family whenever possible, especially if they are better off than their parents. Parents, on the other hand, provide for them through young adulthood and even during marriage. This type of reciprocal relationship is a lifelong expectation.⁵ An interesting case exemplifying how this can become a source of guilt, anxiety, and ultimately, depression, recounts the

¹Ibid., 230-231.

²C. Carillo, “Changing Norms of Hispanic Families,” in *Minority Mental Health*, ed. E. E. Jones and S. J. Korchin (New York, NY: Praeger, 1982), 250-266.

³Ibid.

⁴A. M. Padilla and N. S. DeSnyder, “Counseling Hispanics: Strategies for Effective Intervention,” in *Handbook of Cross-cultural Counseling and Therapy*, ed. P. B. Pedersen (Westport, CT: Greenwood, 1985), 157-164.

⁵E. Mizio, “The Impact of Macro Systems on Puerto Rican Families,” in *The Psychosocial Development of Minority Group Children*, ed. G. J. Powell et al. (New York, NY: Brunner/Mazel, 1983), 216-236.

experience of a thirty-five-year-old Mexican American, José, who visited a clinic complaining of anxiety attacks.¹ The precipitating event appeared to be his impending marriage, which would force him to reduce the amount of money he sent to his parents in Mexico. He felt that it would be a sin to reduce his assistance. The counselor, assisted by the priest, helped him to understand that he was not committing a sin, and he was eventually able to reconcile with the idea that it would be acceptable for him to send less money to his parents.

Young people get married quite young, and soon become parents. This is usually encouraged, and it is considered a positive and stabilizing influence. Children are welcome and are a source of great pride.² However, youthful marriages are vulnerable to dissolution, and since divorce is much less acceptable and less often seen as an alternative to marital difficulties, when it does happen, the feelings of isolation and guilt can easily contribute to depression.³

Religion plays a very important role in the life of most Hispanics, the majority of whom come from Catholic backgrounds. There is a strong belief in God, and in the importance of prayer; but there is also a more fatalistic approach to life, understanding

¹This case is presented by F. X. Acosta and L. A. Evans, "Effective Psychotherapy for Low-income and Minority Patients," in *Effective Psychotherapy for Low-income and Minority Patients*, ed. F. X. Acosta, J. Yamamoto, and L. A. Evans (New York, NY: Plenum, 1982), 51-82.

²Sue and Sue, 233.

³W. A. Vega, R. L. Hough, and A. Romero, "Family Life Patterns of Mexican-Americans," in *The Psychosocial Development of Minority Group Children*, ed. G. J. Powell et al. (New York, NY: Brunner/Mazel, 1985), 194-215.

misfortunes as inevitable. As a result many Hispanics have difficulty behaving assertively, and working toward changing “their fate.”¹

Other values held by many Hispanics, which differ from those held by middle-class Americans, include their present orientation versus the more future-oriented Caucasian mind- set, the respect for the elderly and those in authority, their strong concept of honor and human dignity, and the clearly delineated sex roles characterized by a dominant-male and submissive-female pattern.²

Migration—which has forced separation—and the acculturation process to new values and customs—to which many times there is strong resistance—also produce strain and stress among many Hispanics, especially on the areas of family structure, ethnic identification, and sex role expectations.³ Hispanics have been reluctant to “melt into” the dominant culture at the expense of their own idiosyncracies.⁴

The most recent immigrants often have feelings of estrangement and displacement in the United States due to culture conflict, the disruption of the extended family, the language barrier, and the added clashes resulting from intergenerational conflicts caused by differences in rates of acculturation—young people obviously adapting and assuming

¹Sue and Sue, 230-232.

²Ibid., 231-232.

³Ibid., 233-237.

⁴D. R. Atkinson, “Ethnic Similarity in Counseling Psychology: A Review of Research,” *The Counseling Psychologist* 11 (1983): 79-92.

the new values much quicker.¹ For example, Cuban elders expected they would be awarded a high status later in life and would become the ultimate authority in the family. This expectation has not been met, and instead they are often considered burdens to the family, resulting in feelings of isolation and depression.² Other authors feel that the pressures in acculturation versus the pressures to remain ethnically loyal are common in Hispanics, and can be an important cause of additional stress.³

Another important stressor to Hispanics in North America can be their level of proficiency in English, which they know plays a crucial role on their road to higher achievement in this society, but becomes harder to master the older they are when they immigrate.⁴ Additional factors, some of them beyond their control, such as prejudice and discrimination, and others difficult to overcome, such as poverty, should not be underestimated either.

Although all this information is vital, as was mentioned before, it can be misused if generalizations are made in a stereotypical fashion, since there are large differences in terms of values, acculturation level, and the problems faced by each individual.

¹Sue and Sue, 237.

²J. Szapocznik et al., "Theory and Measurement of Acculturation," *International Journal of Psychology* 12 (1978): 113-130.

³E. S. LeVine and A. M. Padilla, *Crossing Cultures in Therapy: Pluralistic Counseling for the Hispanic* (Monterey, CA: Brooks/Cole, 1980), 105-113.

⁴Sue and Sue, 236.

Previous Studies on Depression Among the Hispanics in North America

As for the incidence of depression among Hispanics as compared to other ethnic groups, the Epidemiologic Catchment Area Study (ECA) is one of the most important data sources available to describe the epidemiology of selected major mental disorders in adults.¹ In this study, over 20,000 persons ages eighteen and older were interviewed and specific psychiatric disorders (including major depression and dysthymia) were identified. Survey data were obtained in two waves a year apart on the same initial sample, which enabled the calculation of depressive episodes, as well as incidence rates over various time periods—one month, one year, and lifetime.² Therefore, “the ECA data provide one of the most comprehensive community-based surveys of depression in existence.”³

In the ECA study, ethnic variability in prevalence of major depression was not dramatic. Among ethnic groups, however, the lifetime prevalence of major depressive disorder was highest for Whites (Whites 5.1%, Hispanics 4.4%, Blacks 3.1%), while that for dysthymia was highest among Hispanics (Hispanics 4.0%, Whites 3.3%, Blacks 2.5%). Blacks had lower estimates of major depression and dysthymia than other ethnic groups, even though they had higher estimates for some depressive symptoms such as change in

¹D. A. Regier and L. Robins, “Introduction,” in *Psychiatric Disorders in America*, ed. L. Robins and E. Regier (New York, NY: Free Press, 1991), 1-10.

²W. W. Eaton et al., “The Incidence of Specific DIS/DSM-III Mental Disorders: Data from the NIMH Epidemiologic Catchment Area Program,” *Acta Psychiatrica Scandinavica* 79 (1989): 163-178.

³Charles T. Kaelber, Douglas E. Moul, and Mary E. Farmer. “Epidemiology of Depression,” in *Handbook of Depression*, ed. E. Edward Beckham and William Leber (New York, NY: Guilford, 1995), 8-9.

appetite patterns and loss of interest.¹ Hispanics also had the highest one-year prevalence for major depressive disorder (Hispanics 3.3%, Whites 2.8%, Blacks 2.2%).²

The percentages of depressive illness reported by ECA, though, tend to be low when compared with other studies such as the National Comorbidity Survey (NCS), which found “substantially higher estimates of dysthymia, major depressive episodes, and other psychiatric disorders than did the ECA study.”³ But this latter study did not investigate ethnic groups within the total sample population, so we do not have additional data on Hispanics to compare. Nonetheless, while the ECA study reported an overall lifetime prevalence of major depression of 6.3% (3.6% among men, and 8.7% among women), the NCS study reported 17.1% (12.7% in men and 21.3% in women). Similar and even greater differences can be found in other areas and other studies. According to Kaelber, Moul and Farmer, “when studies disagree, differences may arise from differing methodologies, rather than from different risks of disease occurrence and/or persistence.”⁴

The necessary task of developing high-specificity criteria for case definitions remains unfinished. . . . Although more objective criteria for defining specific disorders are now available, operationalizing these criteria in clinical and epidemiological investigations remains inexact for most mental and behavioral disorders, including depressive disorders.⁵

¹P. D. Somervell et al., “The Prevalence of Major Depression in Black and White Adults in Five United States Communities,” *American Journal of Epidemiology* 130 (1989): 725-735.

²Kaelber, Moul, and Farmer, 11.

³Ibid., 13.

⁴Ibid., 6.

⁵Ibid.

Therefore, it is important to keep in mind that these percentages could be much higher than what the conservative figures of the ECA report presents.

Using data obtained as a part of the Hispanic Health and Nutrition Examination Survey (HHANES), findings from the Cuban-American population included in that survey were reported.¹ The study found 10 percent of this group presented cases of major depression episodes, and the lifetime, six-month, and one-month prevalence estimates were 3.2 percent, 2.1 percent, and 1.5 percent respectively. Among Mexican-Americans their results indicated that 13.3 percent of the sample population showed cases of major depression episodes.²

A Biblical Perspective on Depression

Neither the word depression nor its ancient equivalent—"melancholia"—appear in the Bible. Nevertheless, clear descriptions of depressive symptoms can be found in several of its books. According to Dr. Archibald Hart, "biblical terms such as *despair*, *cast down*, *sad*, and *sighing* all refer to forms of the depressive syndrome."³

Several biblical characters suffered from depression, to the point of expressing their wish that God would take their lives. In Num 11:15, Moses prays: "If this is how you are going to treat me, put me to death right now—if I have found favor in your

¹These findings were reported in W. E. Narrow et al., "Depression among Cuban Americans: The Hispanic Health and Nutrition Examination Survey," *Social Psychiatry and Psychiatric Epidemiology* 25 (1990): 260-268.

²Kaelber, Moul, and Farmer, 11.

³Hart, 7.

eyes—and do not let me face my own ruin.” Elijah also requested God to take his life during his depressive episode (1 Kgs 19:4), and Job expressed his death wish when he cursed the day of his birth and said: “Why is light given to those in misery, and life to the bitter of soul; to those who long for death that does not come; who search for it more than for hidden treasures” (Job 3:20-21).

Indeed, Job’s experience exemplifies a typical case of depression resulting from losses. He began by losing most of his possessions; immediately after, all ten of his children were tragically killed; and finally he lost his health. In Job 2, this man of God is sitting in a pile of ashes, covered from head to foot with boils, and scraping his body with pottery. Not long after, the symptoms of depression began showing in his life: he curses the day he was born (3:1); he describes the day of his birth as “darkness,” “shadow,” “blackness,” and “cloud ”(3:5); he hopes “its morning stars become dark,” expressing his temporary hopelessness (3:9); he wishes he had died at birth (3:11); he longs for a death that does not come (3:21); he describes his unrelenting agony by stating, “The arrows of the Almighty are in me, my spirit drinks in their poison; God’s terrors are marshaled against me” (6:4). Job had fallen into the black hole of depression.¹ And yet, in looking at Job, we find that (in God’s own words) “there is no one on earth like him, he is blameless and upright, a man who fears God and shuns evil” (Job 1:8).

Other symptoms of depression, such as loss of appetite, are seen in the story of Ahab, who could not get Naboth’s vineyard (1 Kgs 21:4), in Hannah, whose womb the

¹Don Baker and Emery Nester, *Depression: Finding Hope & Meaning in Life’s Darkest Shadow* (Portland, OR: Multnomah, 1983), 27-28.

Lord had shut up (1 Sam 1:7), and in Saul, when he heard the prophecy of Samuel that Israel would be delivered into the hands of the Philistines (1 Sam 28:23).¹

Episodes of depression seem to have distressed Jonah (Jonah 4:1-3), and the whole nation of Israel (Exod 6:9). Jeremiah the prophet wrote a whole book of lamentations, and also requested God to take his life (Lam 1-5). Elijah, after watching God's mighty power at work on Mount Carmel, fled into the wilderness and plunged into desperation when Jezebel threatened his life. He wanted to die and might have done so except for the "treatment" received by an angel sent by God (1 Kgs 19:1-13).

The Psalms are full of cries for help. In them, David uncovers his soul before God expressing his innermost feelings, and leaving us with a clear picture of the depressive episodes which anguished him. Examples of this are Pss 6:6-7; 40:12; 69; 88; and 102. These songs and poems have been an important source of comfort to other people experiencing despair, sadness, and depression. But it is important to point out that, even though they express despair, they are set in a context of hope.

In Ps 43:5, David expresses depression but also rejoicing when he writes: "Why are you downcast, O my soul? Why so disturbed within me? Put your hope in God, for I will yet praise him, my Savior and my God."

Jesus himself, while praying in the Garden of Gethsemane, was greatly distressed: "He took Peter and the two sons of Zebedee along with him, and he began to be sorrowful and troubled. Then he said to them, 'My soul is overwhelmed with sorrow to the point of death. Stay here and keep watch with me'" (Matt 26:37-38). The Amplified Bible

¹Hart, 7.

describes this experience in even more graphic terms: “He began to show grief and distress of mind and was deeply depressed. Then He said to them, My soul is very sad and deeply grieved, so that I am almost dying of sorrow.”

And Paul wrote, “For when we came into Macedonia, this body of ours had no rest, but we were harassed at every turn—conflicts on the outside, fears within. But God, who comforts the downcast, comforted us by the coming of Titus” (2 Cor 7:5-6).

All of these examples are consistent with the realism that characterizes the Bible, and show that depression has always been a part of human experience.

It is a realistic despair contrasted with a certain hope. Each of the believers who plunged into depression eventually came through and experienced a new and lasting joy. The biblical emphasis is less on human despair and more on belief in God and the assurance of abundant life in heaven, if not on earth. Paul’s confident prayer for the Romans will someday be answered for all Christians: ‘May the God of hope fill you with all joy and peace as you trust in him, so that you may overflow with hope by the power of the Holy Spirit.’¹

The Bible has much more to say about how to prevent, cope, and alleviate this illness, but those aspects are covered in chapter 5.

Ellen G. White’s Contribution to the Topic

Ellen G. White wrote quite extensively on the topic of depression. There are seventy-three references to “mental depression” among her published works—books, pamphlets, and periodicals. She recognized that “nothing is so fruitful a cause of disease as depression, gloominess, and sadness. Mental depression is terrible.”²

¹Collins, 106.

²Ellen G. White, *Medical Ministry* (Mountain View, CA: Pacific Press, 1932), 106.

Her testimonies include some letters to people suffering from depression, and she also acknowledged that both she and her husband suffered from depression at different times of their lives. Talking about her husband, she wrote:

At times he seemed free and happy, but with dyspepsia pressing upon him he seemed unable to retain hopeful feelings, and in faith to calmly trust in God at all times, claiming his precious promises as his. . . . It seemed to be a struggle with the powers of darkness. Sometimes the trembling faith of my husband would grasp the promises of God, and sweet and precious was the victory then enjoyed. Then again his mind seemed depressed, and to be too weak to hold the victory he had gained.¹

She disclosed her own experiences in these words:

For some months past my spirit has been much depressed. God has seen fit to use me, a feeble instrument, for a few years past by giving me visions. This place I have not desired. I have ever known that it would cause me many hours of anguish of spirit. . . . Messages have been given me, and it has been enjoined upon me to be faithful in declaring them. My feelings have been sensitive, and while with the fear of God before me, I have been obliged to faithfully relate what God has shown me, my sufferings of mind have been intense.²

At times I have been afflicted in body and depressed in spirits, but the Lord has been my Redeemer, my Restorer. Many have been the rich blessings imparted to me. In the time of my greatest need, I have been enabled to hold fast my confidence in my heavenly Father.³

Even in the midst of these difficult periods, she strived to have a positive attitude:

“I am sometimes greatly perplexed to know what to do, but I will not be depressed. I am

¹Ellen G. White, “Our Late Experience,” *Advent Review and Sabbath Herald*, February 27, 1866, 2.

²Ellen G. White, “Communication from Sister White,” *Second Advent Review and Sabbath Herald*, April 22, 1862, 1.

³Ellen G. White, “On the Way to Australia: At Samoa and Auckland,” *Advent Review and Sabbath Herald*, February 16, 1892, 1.

determined to bring all the sunshine into my life that I possibly can.”¹ And she frequently encouraged others to do the same: “Do not give way to depression, but let the comforting influence of the Holy Spirit be welcomed into your heart, to give you comfort and peace.”² In this and other references she emphasized the importance of cheerful thoughts and a positive attitude to prevent depression.

When referring to David’s experiences of discouragement and depression, she acknowledged his lack of trust in God and his errors, but she added that through these experiences David was learning wisdom and coming to realize his weakness and the need to depend constantly upon God. She commented:

Oh, how precious is the sweet influence of the Spirit of God as it comes to depressed or despairing souls, encouraging the fainthearted, strengthening the feeble, and imparting courage and help to the tried servants of the Lord! Oh, what a God is ours, who deals gently with the erring and manifests His patience and tenderness in adversity, and when we are overwhelmed with some great sorrow!³

When referring to the experience of Elijah, she wrote:

Into the experience of all there come times of keen disappointment and utter discouragement—days when sorrow is the portion, and it is hard to believe that God is still the kind benefactor of His earthborn children; days when troubles harass the soul, till death seems preferable to life. It is then that many lose their hold on God and are brought into the slavery of doubt, the bondage of unbelief. Could we at such times discern with spiritual insight the meaning of God’s providence we should see

¹Ellen G. White, *Mind, Character, and Personality* (Nashville, TN: Southern Publishing, 1977), 2:492.

²*Ibid.*, 491.

³Ellen G. White, *Patriarchs and Prophets* (Mountain View, CA: Pacific Press, 1958), 656-657.

angels seeking to save us from ourselves, striving to plant our feet upon a foundation more firm than the everlasting hills, and new faith, new life, would spring into being.¹

And writing about Christ's experience in Gethsemane, she tells about the angel sent from Heaven to strengthen him to drink the cup of suffering, and explains: "Christ's agony did not cease, but his depression and discouragement left him. He still carried the load of guilt, and he fulfilled the demands of the divine law, and glorified the Father by drinking the bitter cup."² Soon after she adds:

The strength given to Christ in the hour of bodily suffering and mental anguish in the Garden of Gethsemane, has been and will be given to those who suffer for his dear name's sake. The same grace given to Jesus, the same comfort, the more than mortal steadfastness, will be given to every believing child of God, who is brought into perplexity and suffering, and threatened with imprisonment and death, by Satan's agents.³

All Ellen G. White quotations dealing with depression reflect her deep empathy, tender care, and insightful understanding of its symptoms and effects. Only once in all of those references does she talk about the sinful nature of despondency—not depression itself—in these terms:

When Job caught a glimpse of his Creator, he abhorred himself and repented in dust and ashes. Then the Lord was able to bless him abundantly and to make his last years the best of his life. Hope and courage are essential to perfect service for God. These are the fruit of faith. Despondency is sinful and unreasonable. God is able and willing 'more abundantly' (Heb 6:17) to bestow upon His servants the strength they need for test and trial.⁴

¹Ellen G. White, *Prophets and Kings* (Mountain View, CA: Pacific Press, 1958), 162.

²Ellen G. White, "Gethsemane," *The Signs of the Times*, June 3, 1897, 1.

³Ibid.

⁴White, *Prophets and Kings*, 164.

Ellen G. White acknowledged the realities of depression and the struggles of those who suffer from it, and provided valuable advice on the causes of depression as well as preventive and coping alternatives. Several of them will be mentioned in later chapters. But above all, when dealing with this issue, her writings—as the biblical references cited before—are filled with words of encouragement and reminders of God’s promises of strength and support:

We are given a special message to bear in times of depression and discouragement: ‘Strengthen the feeble hands, steady the knees that give way; say to those with fearful hearts, ‘Be strong, do not fear; your God will come, he will come with vengeance; with divine retribution he will come to save you. Then will the eyes of the blind be opened, and the ears of the deaf unstopped. Then will the lame leap like a deer, and the mute tongue shout for joy. Water will gush forth in the wilderness and streams in the desert. The burning sand will become a pool, the thirsty ground bubbling springs’ (Isa 35:3-7).¹

Depression among Ministers

Don Baker, one of the several ministers who have written books over the last years disclosing their personal experiences and the struggles they went through to overcome depression, writes, “It is impossible for those who have never been depressed to fully understand the deep, perplexing pain that depression causes.”² He adds:

For four interminable years I appeared healthy, without bandages and without crutches. There were no visible scars, no bleeding, and yet there was the endless, indefinable pain that no doctor’s probing fingers could locate—no drug could totally relieve. There was always the pain and along with it the desire for oblivion—an oblivion that would only come in minute snatches of restless sleep. I seemed to be out of touch with reality. Life was a blur, often out of focus. My life seemed to be

¹Ellen G. White, “Instruction to Ministers,” *Advent Review and Sabbath Herald*, May 6, 1909, 1.

²Baker and Nester, 11.

nothing but pretense and fantasy. No one really cared, I felt—not even God. The only solution—at times—seemed to be suicide. To be told that Christians never get depressed only pushed me deeper into my black hole of depression. The way out of that black hole was a long and painful process—one that required the sensitive and insightful counsel of a friend.¹

Nobody questions that pastors are under great stress. Furthermore, this is not a new phenomenon, since ministry has always been a very challenging profession, and has brought with it many difficulties. Regardless of the causes, these difficulties “tear at the heart of the pastor, but are often hidden from the view of the congregation.”²

Many prominent Christian ministers have suffered from serious emotional difficulties, especially depression. Yet, “most contemporary Christian leaders keep their struggles to themselves,”³ argues Dr. Carlson. But he adds, “when we continually hide our anxiety or depression, we in effect endorse the ‘emotional health gospel,’ which tends to blind us to the teaching of the Word of God on this subject.”⁴ And as has already been presented, the Scriptures tell us that “significant negative emotions plagued some of God’s chosen deliverers and prophets in the Bible.”⁵

An article published in *Christianity Today* quite recently begins by stating, “If you’re a discouraged pastor, you’re in good company—the company of Luther, Calvin,

¹Ibid.

²Swetland, 11.

³Carlson, 40.

⁴Ibid.

⁵Ibid.

Bonar, Morgan, and Spurgeon.”¹

Martin Luther, in spite of playing a key role in the Reformation, inspiring thousands, and writing hymns such as “A Mighty Fortress Is Our God,” suffered from chronic depression. And although he interpreted his emotional struggles as positively as possible, after one extended episode of depression, he confessed, “For more than a week I was close to the gates of death and hell. I trembled in all my members.”² Luther found himself subject to recurrent periods of exaltation and depression of spirit. In his own words “the content of the depressions was always the same, the loss of faith that God is good and that He is good to me.”³

Charles Spurgeon, one of the greatest preachers of all time, who drew ten thousand people to his London church, whose sermons and books have influenced ministers all over the world, and whose dedicated and faithful commitment to Christ nobody doubts, also lived with great emotional problems.

‘From boyhood days dreadful moods of depression repeatedly tormented [him],’ one biographer wrote. His despondency forced him to be absent from his pulpit two to three months out of the year. In 1866 he openly shared his struggles with his congregation: ‘I am the subject of depressions of spirit so fearful that I hope none of you ever get to such extremes of wretchedness as I go [through].’ During these depressions, he said, ‘Every mental and spiritual labor . . . had to be carried on under protest of spirit.’⁴

¹Andre Bustanoby, “How to Cope with Discouragement,” *Christianity Today*, January 7, 1997, 3.

²Martin Luther, quoted in Carlson, 38-39.

³Carlson, 39.

⁴Ibid.

Spurgeon then cited from the biographies of Martin Luther and John Wesley, which have many references to their own experiences of depression.¹ But these experiences of depression, despair, and guilt led these great men of God to understand better His provisions for ministry.

Our own church history has its own account of similar problems. As we have seen, James White suffered from frequent depression, despondency, and overwork. His wife, Ellen, writes that he could have lived longer if others had supported him more adequately.² Some died prematurely, as he did, and others “simply accepted their lot in life, partly because they knew of no alternative (the understanding of health and illness was not as advanced) and partly because of the social structures which made them fear to change.”³ Indeed, as was stated in the introduction, clergy, by the very nature of their calling and profession, may be more prone to depression than others.⁴

Other clergy people who have disclosed their experiences in published books include Jim Conway, senior Baptist pastor of a large church on the edge of a university campus, and C. Welton Gaddy, Presbyterian minister and Seminary teacher. This is the way Conway introduces us to the way he felt and thought at the time of his illness:

¹Hart, 15-16.

²Ellen G. White, *Testimonies for the Church*, 9 vols. (Mountain View, CA: Pacific Press, 1948), 5:67; 3:16-17, 85-88, 495, 500-01.

³Schoun, *Helping Pastors Cope*, 56.

⁴Several authors emphasize this idea. I would especially refer the reader to Hart, 12; and Edgar Mills and John Koval, *Stress in the Ministry* (Washington, DC: Ministries Studies Board, 1971), 9.

In the distance someone was picking at a piano. Pauses of silence, caused by an unpracticed amateur's search for the proper keys, interspersed various musical notes being banged out in such a fashion as faintly to suggest some semblance of the melody of a Christmas carol. "Joy to the World." "Silent Night." Surely not here. Not now. No way. Where I sat listening to this semirhythmic racket seemed about as far removed from a holy night, about as distant from an advent of the Divine that would cause heaven and nature to sing, as earth from sky. I was a new patient in the mental-health unit of a large metropolitan medical facility. I was anxious. I was depressed. I was hurting. . . . For the first time in my life, I did not seem to care much about anything. I had no sense of what had happened to me or of its significance for me.¹

And Gaddy shares his experience in a similar and candid way:

My depression had grown all through the spring, summer, and fall. By October it had reached giant proportions. . . . I had literally come to the bottom of me. I was ready to chuck everything. . . . On a cold wintry night, I went for a long walk and made some decisions. I would resign as pastor of the church, write a letter to Fuller Seminary to tell them I was dropping my doctoral program, and write to my publishers to tell them I no longer would be writing. I would also legally turn everything over to Sally, take only our 1968 Cutlass, and start driving south. For me, it was all over. I had had it with people, with responsibility, with society, even with God, who had been such a close friend all of my adult life. He seemed now to be distant and remote, uninterested in the agony through which I was going.²

In spite of their bleak beginnings, these books—among many others—provide valuable insight into this important issue, and these ministers enrich our knowledge by disclosing their personal experiences, warning us of the dangers, showing us how to better prevent and/or cope with depression, and giving us insights on how they were able to overcome depression in their own lives, and even grow through their experience.

In 1963, Dr. George Anderson, an Episcopal clergyman and, at the time, Director of the Academy of Religion and Mental Health, wrote an article with interesting data on

¹C. Welton Gaddy, *A Soul under Siege: Surviving Clergy Depression* (Philadelphia, PA: Westminster, 1991), 17-18.

²Jim Conway, *Men in Mid-Life Crisis* (Elgin, IL: David C. Cook, 1978), 11-12.

depression among ministers. He stated that the “emotional problems of clergymen are on the increase. . . . More than ten thousand of our Protestant ministers are now receiving some form of individual or hospital psychiatric care.”¹ And this was over thirty years ago!

Additional light into the matter is shed by other studies on depression in the ministry. Ralph Haynes conducted research on clergy depression for which he interviewed twenty-three clergy of the Episcopal Diocese in the San Diego area, all of them ordained ministers for fifteen to twenty-five years. His findings show not only the existence of different types and degrees of depression in the sample group, but even more importantly “the little understanding of either the nature or the taxonomy of depression among these ministers, and the need for more information so that they would be able to identify for themselves what was happening in their lives and how to overcome it.”²

As ministers, we may find it harder than others to admit our weaknesses, but, “just as the first step to spiritual healing involves recognizing we are sinners, the first step to emotional healing involves recognizing we have emotional weaknesses.”³

Only when admitting their presence can we begin to assess their true size and shape. Honesty with ourselves is necessary in order to take the next step of being honest before God. Then we can open ourselves to the Holy Spirit’s guidance regarding the

¹George C. Anderson, “Who Is Ministering to Ministers?” *Christianity Today*, January 18, 1963, 6.

²Ralph D. Haynes, “An Outline of Clergy Depression with Suggested Procedures and Strategies for Healing” (D.Min. dissertation, Fuller Theological Seminary, 1986), 1, 5, 218.

³Carlson, 137.

existence and causes of our problems. . . . After being honest with ourselves and with God, objective assessment and healing often requires us to be honest with at least one other human being.¹

Another study I would like to refer to is even more significant because the sample population was Hispanic Protestant Ministers. This research, conducted by Polischuk, studied in cross-cultural comparison the personality characteristics and role preferences of Hispanic Protestant ministers by administering the Minnesota Multiphasic Personality Inventory (MMPI) and the Inventory of Religious Activities and Interests (IRAI) to a voluntary sample of eighty-seven Hispanic ministers of the Greater Los Angeles area. This study showed “statistically significant elevations in scales measuring an ideal image, depression, somatization, non-conformity, aggression, and anxiety among the sample population in comparison to their Anglo counterparts.”² “They were more idealistic, prone to depression, more introverted, and more open in confessing problems.”³

Furthermore, “Hispanic ministers responded to MMPI items on the depression scale in such a fashion that the inference might be drawn that these individuals are likely to be mildly depressed, worrying and pessimistic.”⁴ However, as Polischuk states, “seen in the context of existing normative Hispanic data, such elevations might have reflected

¹Ibid., 137-138.

²Pablo Polischuk, “Personality Characteristics and Role Preferences among Hispanic Protestant Ministers” (Ph.D. dissertation, Fuller Theological Seminary, 1980), 1.

³Ibid.

⁴Ibid., 155.

cultural idiosyncracies in responding to psychological measures.”¹

Dr. Archibald Hart quoted a report by the Chicago *Tribune* published on November 30, 1980, in which the director of the Adult Chemical Dependency Treatment Unit at St. Mary’s Hospital in Minneapolis, Minnesota, said, “Doctors, lawyers, and clergymen have the most problems with drug abuse, alcoholism, and suicide.”² Dr. Hart expresses doubts that many of the alcoholic ministers were from evangelical denominations, and concedes that since no specific details are given as to the backgrounds of the ministers cited in the report, no definite conclusions can be drawn, but he adds:

The hidden problem behind these is very often depression, and these tragedies may merely serve to mask the real underlying problem. . . . From my experience in working with many ministers I can categorically say that equivalents of this problem *do* exist among evangelical pastors.³

I would be unfair, though, if I did not mentioned here the many compensations and greatly rewarding experiences most ministers experience. For most ministers the spiritual rewards of Christian service are so satisfying that they outweigh by far the loneliness, despair, and stress they so frequently undergo. Nevertheless, “too many pastors never achieve this level of satisfaction, and we need to be honest enough in our evaluation to confront the real reasons for this.”⁴

¹Ibid., 2.

²Quoted in Hart, 12.

³Hart, 12.

⁴Ibid., 13.

CHAPTER III

RECOGNIZING DEPRESSION—TYPES, SYMPTOMS, CAUSES, AND CONSEQUENCES

Types of Depression

Different classifications of depression have been suggested and used over the years, such as the neurotic-psychotic, the reactive/exogenous-endogenous, and the primary-secondary distinctions,¹ but I will refer to the clinical criteria (i.e., symptoms and behavioral signs) to classify subtypes of depressive experiences as briefly presented in the introduction, and approved by the American Psychiatric Association.

As mentioned above, for mental health professionals the word depression refers to a group of illnesses called *mood disorders*, “disorders that have a disturbance in mood as the predominant feature.”² Mood disorders are divided into four groups—depressive or unipolar disorders, bipolar disorders, mood disorders due to a general medical condition, and substance-induced mood disorders. But before defining these four groups further, it is important to understand what is meant by four key medical terms that refer to

¹E. Edward Beckham, William R. Leber, and Lorraine K. Youll, “The Diagnostic Classification of Depression,” in *Handbook of Depression*, ed. E. Edward Beckham and William Leber (New York, NY: Guilford, 1995), 41-44.

²American Psychiatric Association, 317.

pathological episodes which characterize these mood disorders, and determine their type. These definitions are based on the *Diagnostic and Statistical Manual*, 4th (also known as DSM-IV). Specific symptoms will be discussed later:¹

1. *Major Depressive Episode*: Diagnosed when five or more depressive symptoms have been present during the same two-week period, and they represent a change from previous functioning. At least one of the symptoms should be either (a) depressed mood or (b) loss of interest or pleasure. The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, and should not be due to the effects of substance abuse, medication, a general medical condition (e.g., hypothyroidism), or bereavement—grief related to the loss of a loved one—for a period longer than 2 months.

2. *Manic Episode*: Defined by a distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least one week, during which three or more specific symptoms have been present. Again, the symptoms should cause marked impairment in occupational functioning, and should not be due to the effects of substance abuse, medication, or a general medical condition.

3. *Mixed Episode*: Meets the criteria of both a manic episode and a major depressive episode nearly every day during at least a one-week period.

4. *Hypomanic Episode*: A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least four days, clearly different from the usual nondepressed mood, and during which three (or more) specific symptoms have been

¹Ibid., 320-321.

present. There should be unequivocal change in functioning, observable by others, but not severe enough to cause marked impairment in social or occupational functioning.

Keeping this in mind, I now summarize the most important characteristics of each of the four mood disorders listed above.¹

Depressive or Unipolar Disorders

Depressive or unipolar disorders are characterized by the presence of depressive episodes, and are distinguished from bipolar disorders by the fact that there is no history of manic, mixed, or hypomanic episodes. They include three different categories:

1. *Major Depressive Disorder*: Characterized by one or more major depressive episodes. It may last months and sometimes years, and if left untreated, it may not go completely away.
2. *Dysthymic Disorder*: Characterized by at least two years of depressed mood for more days than not, accompanied by additional depressive symptoms that do not meet criteria for a major depressive episode. The person suffering from dysthymia can function, but not at full capacity.
3. *Depressive Disorder Not Otherwise Specified*: Defines disorders with depressive features that do not meet the criteria for either of the previous ones, or depressive symptoms about which there is inadequate or contradictory information.

¹All the definitions on this section come from the American Psychiatric Association, 320-321.

Bipolar Disorders

Bipolar disorders involve the presence (or history) of manic, mixed, or hypomanic episodes, usually accompanied by the presence (or history) of major depressive episodes.

They include four different subgroups:

1. *Bipolar I Disorder*: Characterized by one or more manic or mixed episodes (and under certain circumstances hypomanic episodes) usually with a history of major depressive episodes.
2. *Bipolar II Disorder*: Characterized by one or more major depressive episodes accompanied by at least one hypomanic episode.
3. *Cyclothymic Disorder*: characterized by at least two years of numerous periods of hypomanic symptoms that do not meet criteria for a manic episode and numerous period of depressive symptoms that do not meet criteria for a major depressive episode.
4. *Bipolar Disorder Not Otherwise Specified*: Defines disorders with bipolar features that do not meet criteria for any of the specific bipolar disorders previously defined, or those for which there is inadequate or contradictory information.

Mood Disorder Due to a General Medical Condition

This disorder is characterized by a prominent and persistent disturbance in mood that is judged to be a direct physiological consequence of a general medical condition.

Substance-Induced Mood Disorder

This disorder consists of a prominent and persistent disturbance in mood that is judged to be a direct physiological consequence of a drug of abuse, a medication, another

somatic treatment for depression, or toxin exposure.

Although it is important to understand these classifications because they provide the background for this research, the extensiveness and complexity of the topic prevents us from looking in detail at all of these groups and subgroups of mood disorders. Therefore, the scope of this research is limited to major depression episodes, and it is to these that I refer when presenting symptoms, causes, and other data in this chapter. The Zung survey for the quantitative measurement of depressive symptomatology—sent to the pastors, and used as the base of this research—is also designed to detect only the possible presence of major depression episodes, regardless of the diagnostic type involved.

Symptoms of Depression

As mentioned above, depression may be considered normal under specific circumstances—such as the grief over the loss of a loved one and/or other significant psychological losses—and within certain parameters of intensity and time. But “depressive episodes are distinguished from more ordinary fluctuations by the severity and duration of symptoms and by the effect of these symptoms on functioning.”¹ Indeed, “depression, depending on its intensity and severity, can be hellish, a trauma in which one is both miserable and overcome with feelings of helplessness, powerlessness, and hopelessness.”²

¹Kaelber, Moul, and Farmer, 5.

²Hulme and Hulme, 19.

It is obviously easier to recognize a person who has severe depressive illness—with clearly defined symptoms, such as profoundly disturbed sleep, weight loss, or thoughts of suicide—but it is also crucial to recognize depression episodes before they reach those extremes, while they are still mild, or even better, minimal. It is not always easy to do so, though, because many times “depression is masked behind physical symptoms,”¹ and the symptoms of patients suffering from mild depression “may be subtle, and often manifest themselves primarily as low self-esteem, chronic worry, irritability, temper outbursts, and marital problems.”² The danger is, then, that these signs can easily be overlooked or misdiagnosed leaving the person without the correct treatment.

Other obstacles to a correct diagnoses could be a “person’s difficulty in concentrating, his/her impaired memory, or a tendency to deny, discount, or explain away the symptoms.”³ In other words, depressed people do not always recognize or understand their condition. This is one of the reasons why additional informants—such as friends or family members—can be especially helpful in clarifying a current or prior major depressive episode. “Depression is often observed first by those who live with or know the depressed person. They notice deviations from the person’s usual behavior patterns.”⁴

The following symptoms may be present and indicative of a major depressive episode. The nature of these symptoms may be classified as “physical” and

¹Ibid.

²Quinn, x.

³American Psychiatric Association, 322.

⁴Hulme and Hulme, 19-20.

“psychological” although, according to Beckham, Leber, and Youll, this division “should not be taken so literally as to assume that these symptom lists reflect on the etiology of depression.”¹ Still, it does help to demonstrate that depression is as much a physical disorder as a psychological one, and

it can be useful to compare clinical depression with an illness patients are familiar with, such as influenza. Patients with the flu can do things that a physician suggests will hasten recovery, but they cannot will the flu away. Nor did they contract the illness because they were weak. Analogies such as this can provide patients with a framework that appeals to common sense and competes with shame-inducing explanations of their depression.²

Physical Symptoms

1. *Disturbance of appetite*: Most depressives have poor appetite and lose weight. Many individuals feel they have to force themselves to eat. Other individuals, however, react by eating more. “They overeat, particularly sweets, as though they are trying to find some pleasure through taste, a brief escape from their miserable feelings.”³ When appetite changes are severe (in either direction), there may be a significant loss or gain in weight. In children, a failure to make expected weight gain may be a symptom of depression.⁴

2. *Sleep disturbances*: Insomnia is an extremely common feature of depression. Individuals may have middle insomnia (i.e., waking up during the night and having difficulty returning to sleep), terminal insomnia (i.e., waking too early and being unable to

¹Beckham, Leber, and Youll, 37.

²Ibid.

³Hulme and Hulme, 20.

⁴American Psychiatric Association, 327.

return to sleep) or initial insomnia (i.e., difficulty falling asleep).¹ Typically, the individual feels worse in the morning and has much difficulty getting out of bed and starting the day's activities. As the day goes on, the person begins to feel somehow better and by evening may feel reasonably well. But the next morning the cycle begins again and repeats itself each day.² In some cases, the sleep disturbance, like the appetite disturbance, takes the form of excess rather than deficiency, with the patient sleeping all day long.³

3. *Psychomotor changes*: These include agitation (e.g., the inability to sit still, pacing, hand wringing, moaning, rubbing of the skin) or retardation (e.g., slowed speech, thinking, and body movements, increased pauses before answering, speech that is decreased in volume, amount or variety of content, or in extreme cases, a mute stupor).⁴ These changes must be severe enough to be observed by others.⁵

4. *Decreased energy, tiredness, and fatigue*: These are common and may be present nearly every day. There is a sharp reduction of the general energy level.

Depressed people feel as if they have run out of gas. They complain about fatigue, feel that everything is an effort, that they just can't get going, that their body feels heavy or leaden, that they are listless and slowed down. They find themselves unable to achieve their usual goals.⁶

¹Bootzin, Acocella, and Alloy, 241.

²Hulme and Hulme, 21.

³Klein and Wender, 19-20.

⁴Bootzin, Acocella, and Alloy, 241.

⁵American Psychiatric Association, 327.

⁶Klein and Wender, 21-22.

In fact, a person may report sustained fatigue without physical exertion. Even the smallest tasks seem to require substantial effort. For example, an individual may complain that washing and dressing in the morning are exhausting and take twice as long as usual.

Psychological Symptoms

1. *Depressed mood*: “Almost all severely depressed adults report some degree of sadness or unhappiness, ranging from a mild melancholy to total hopelessness.”¹ The person may describe his mood as utter despair, loneliness, boredom, discouragement, the “blues,” “down in the dumps,” or in many other ways.² In some cases, sadness may be denied at first, but may be confirmed at an interview by noticing, for example, that the individual looks as if he or she is about to cry. In other individuals who complain of feeling “blah,” having no feelings, or feeling anxious, the presence of a depressed mood can be inferred from the person’s facial expression and demeanor.³

Some individuals emphasize somatic complaints (e.g., headaches, backaches, dizziness, heart palpitation, tightening of the chest, trouble breathing, or other bodily aches and pains) rather than reporting feelings of sadness. Many individuals exhibit increased irritability (e.g., persistent anger, a tendency to respond to events with angry outbursts or blaming others, or an exaggerated sense of frustration over minor matters).⁴

¹Bootzin, Acocella, and Alloy, 241.

²Klein and Wender, 17.

³Bootzin, Acocella, and Alloy, 241.

⁴Klein and Wender, 17-18.

It is important to differentiate the sadness and grief caused by the death of a loved one, the loss of a job or other disturbing events, with that of the depressive illness. “The early symptoms of intense grief often resemble some of the symptoms of depressive illness. . . . The person may cry easily and have trouble sleeping. He may lose appetite and some weight.”¹ But while sadness and grief clear up in a reasonable period of time, and then a person gets back to normal, in depressive illness they continue for months, deepening over time and impairing the person’s ability to function. The persistence or worsening of these feelings and the appearance of other symptoms will be the clue that this is not normal sadness or grief, or if it began as such it has developed into depression.

2. *Loss of interest, pleasure, and/or affection:* Aside from a depressed mood, the most common characteristic of a major depressive episode is this loss or markedly diminished affection for people, and interest or pleasure in almost all activities. It may begin with a lessening of the expression of affection for the spouse and/or children and it grows until they really do not care about themselves, others or anything. “Depression sabotages relationships with friends and family members in whom one depends for help when trouble strikes. Family and longtime friends begin to drift away.”² The person may feel he/she wants to be left alone all the time. Furthermore, this symptom may contribute to a deepening spiral of depression since the person may feel guilty for the way he/she is behaving. He/she may conclude that he/she is a horrible person rather than seeing that

¹Quinn, 5.

²Klein and Wender, 31.

he/she may be acting horribly because of an illness.¹

This disinterest extends also to a job and/or career—leading many to question themselves if what they are doing is really worthwhile, or if they should get into something completely different²—to the general appearance and personal attire, and to hobbies or other activities which gave the person pleasure before.

The absence of pleasure, known as anhedonia, is generally far-reaching. Whatever the person used to like to do . . . no longer seems worth doing. To the depressed person, food no longer tastes good, sex no longer feels good, friends are no longer interesting to talk to. Severely depressed patients may experience a complete “paralysis of the will”—an inability even to get out of bed in the morning.³

3. *Feelings of worthlessness or excessive and inappropriate guilt:* These may include unrealistic negative evaluations of one’s worth or guilty preoccupations over minor past failings.⁴ Such individuals often misinterpret trivial day-to-day events as evidence of personal defects and have an exaggerated sense of responsibility for these events. “They feel trapped by the circumstances that brought on the depression and can envision no way out. Their past is filled with rejection and grief, their present becomes anguish personified, and their gloomy outlook on the future contemplates no solution.”⁵ This sense of worthlessness or guilt may acquire delusional proportions (e.g., the

¹Quinn, 50.

²Ibid., 49.

³Bootzin, Acocella, and Alloy, 241.

⁴Klein and Wender, 29.

⁵Tim LaHaye, *How to Win Over Depression* (Grand Rapids, MI: Zondervan, 1974), 31.

individual may be convinced that he or she is personally responsible for world poverty).¹

4. *Diminished ability to think, concentrate, or make decisions:* Many individuals report impaired ability in these areas as depression creeps into their lives. They may appear easily distracted or complain of memory difficulties.

Depressed people have many complaints about their mental functioning. They feel that their memory is short and that they cannot pay attention. In addition, they often behave in an extremely indecisive and perplexed fashion, as if they just don't know what to do or can't figure things out.²

Those in intellectually demanding academic positions are often unable to function adequately as a result of their lack of concentration.

5. *Increased use of intoxicants and/or drugs:* Those suffering from depression may be using alcohol, marijuana, or other drugs as mental anesthetics and temporary distractions. They are attempting to medicate themselves. However, because these substances do not lift the depression, they usually increased consumption in the search for symptom relief.³

6. *Recurrent thoughts of death, suicidal ideation, or suicide attempts:* These thoughts range from a belief that others would be better off if the person were dead, to recurrent thoughts of committing suicide or actual specific plans of how to commit suicide. The frequency, intensity, and lethality of these thoughts vary widely. Severely suicidal individuals may have acquired materials (e.g., a rope or a gun) to use in the

¹Bootzin, Acocella, and Alloy, 242.

²Klein and Wender, 30.

³Ibid., 33.

suicide attempt, and may have established where and when they will be alone so that they can accomplish the suicide.¹ Motivations for suicide may include a desire to give up in the face of perceived overwhelming obstacles or an intense wish to end an intensely painful emotional state perceived to be without solution.

Depression is like falling off an emotional cliff from which you cannot seem to recover. It is hopeless sadness combined with unreasoning anxiety and deadly fear. It is mental pain so severe that at times death seems preferable. It is carrying a feeling of the most profound grief, but without profound reasons for it. In deep depression you feel as if there is no future; every effort would be hopeless, every attempt a failure.²

Other symptoms of depression may include hostility, irritability, and anger—first directed to others, and later turned inward at oneself. It is not uncommon to hear a depressed person mutter, “I hate myself,” or “I get so disgusted with myself.” Feelings of anxiety, fear, worry, and loneliness may also be present.³

According to the American Psychiatric Association,

The degree of impairment associated with a Major Depressive Episode varies, but even in mild cases there must be either clinically significant distress or some interference in social, occupational, or other important areas of functioning. If impairment is severe, the person may lose the ability to function socially or occupationally. In extreme cases, the person may be unable to perform minimal self-care (e.g., feeding or clothing self) or to maintain minimal personal hygiene.⁴

As stated above, for a diagnosis of major depressive episode, these symptoms should “be present during the same 2-week period and represent a change from previous

¹Bootzin, Acocella, and Alloy, 262.

²Peter Mariner, “The Hopeless Feeling,” *Adventist Review*, January 22, 1998, 25.

³Klein and Wender, 35-36.

⁴American Psychiatric Association, 322.

functioning. At least one of the symptoms should be either (1) depressed mood or (2) loss of interest or pleasure.”¹

It is essential to keep in mind, though, that any “two people with the same type of mood disorder may have somewhat different symptoms and problems as a result of those symptoms.”² Therefore, if any of these symptoms are present, it is vital to get help.

Stress and Burnout

Since some of the symptoms just mentioned are similar to those experienced by people suffering from stress and/or burnout, it may be useful to explain briefly what these two increasingly common problems are, including their similarities, differences, and/or relation with depression.

Stress

Life is not possible without stress. In fact, “complete freedom from stress would be death.”³ Stress has been defined as

the sum of the biological reactions to any stimulus—pleasant or unpleasant; physical, mental, or emotional; internal or external—that tends to disturb the organism’s homeostasis—the state of stability and consistency in the physiological functioning of an organism.⁴

¹Ibid., 327.

²Quinn, 47.

³Paul M. Insel et al., *Core Concepts in Health* (Mountain View, CA: Mayfield, 1991), 18.

⁴Ibid., 19.

Dr. Hans Selye, an endocrinologist and biologist, popularized the terms *eustress* and *distress*.¹ Eustress refers to stress that is pleasant, the stimulus that keeps the mind and body functioning properly, pushing capacities to the limit, and strengthening the person for future efforts. “It can be beneficial; many of us perform best when under stress.”² Distress, on the other hand, is an unpleasant stress state believed to cause illness and leads to a decline in the body’s immune response.³

All types of stressors, no matter what their source, trigger the same physiological responses. “Stress prepares us for action. The signals or stressors move our bodies to be ready for ‘fight or flight.’”⁴ So the problem does not lie in the presence of stress, but in the level of stress that each individual can control, and/or adapt to, above which, disaster is waiting to strike.⁵ Each person must discover his/her resources and limitations. “We can squander our resources or we can learn to make these resources last by using them sparingly in worthwhile causes—if possible, in those that cause the least distress.”⁶

¹Hans Selye, “The General Adaptation Syndrome and the Disease of Adaptation,” *Journal of Clinical Endocrinology* 6 (1947): 117-130.

²Harold C. Warlick, *How to Be a Minister and a Human Being* (Valley Forge, CA: Judson, 1982), 32.

³Insel et al., 32.

⁴Walter Cannon, the pioneer stress researcher of Harvard University, quoted in William E. Hulme, *Managing Stress in Ministry* (San Francisco, CA: Harper & Row, 1985), 17.

⁵Roy Oswald, *Clergy Self-Care: Finding a Balance for Effective Ministry* (Washington, DC: Alban Institute, 1991), 24, 39.

⁶Winton H. Beaven, “The Crisis of Stress,” *Ministry*, May 1996, 11.

A very interesting study on stress in ministry, conducted by Mills and Koval among almost five thousand Protestant clergymen,¹ showed that nearly three out of four ministers had experienced periods of major stress in their ministry. This confirms that “the vocation of ministry is far from being a haven from the stresses of life.”²

Some of the symptoms of overstress include gastric distress, disturbed cardiorespiratory activity, restless activity, self-conscious activity, feelings of fatigue and lack of energy, and headaches.³ Among the consequences of pushing our resources beyond their threshold level of stress, we may include a decrease in perception, a perceived loss of options, regression to infantile behavior, inability to make changes in destructive relationship patterns, fatigue, physical illness (including ulcers, muscular back pain, strokes, and heart attacks), and depression.⁴

It is here that we find the relation between stress and depression. High levels of stress may be conducive to depression. Stress may be, therefore, a step leading to depression. Not all distress results in depression, though, just as not all depressions are preceded by high levels of stress, but we need to be aware of this connection, and detect and control our level of stress before it results in negative consequences.

¹Mills and Koval, 9.

²Hart, 12.

³Archibald D. Hart, *The Hidden Link Between Adrenalin & Stress* (Waco, TX: Word, 1986), 20.

⁴Oswald, 44-47.

Burnout

“Burnout is a word we use when a person has become exhausted with his or her profession or major life activity.”¹ “It is a stress-produced syndrome characterized by emotional exhaustion,”² “a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward.”³ It is a serious phenomenon specially common among doctors, nurses, counselors, pastors, social workers, and others in helping professions. Actually, it is seen as an “overuse of listening or caring capacities,”⁴ “a direct result of certain conditions inherent in the work of those in the helping or ‘human services’ professions.”⁵ Among these conditions are:

insufficient training for complex work with other humans, work overload with no clear work boundaries, too many hours spent doing work that is not appreciated, . . . too much bureaucratic constraint with too little work flexibility, and too great a gap between aspiration and accomplishment.⁶

Obviously, this shoe fits ministry very well! Roy Oswald estimates that at least one in every four clergymen is burned out, and he adds:

These clergy still perform their pastoral functions with skill and concern, but they have lost their zest and vitality. They have become dull, hollow, and uninteresting,

¹John A. Sanford, *Ministry Burnout* (New York, NY: Paulist, 1982), 1.

²Warlick, 31.

³Herbert Freudenberger, *Burnout: The High Cost of High Achievement* (Garden City, NY: Anchor, 1980), 13.

⁴Oswald, 58.

⁵Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 113.

⁶Ibid.

and they know it. The tragedy is that these are probably some of our most dedicated and committed clergy. They are not really dull and uncreative; they have simply given so much of themselves for so long that they are burned out.¹

Some of the most common symptoms of burnout are: “difficulty in sleeping, somatic complaints such as weight loss, lack of interest in food, headaches, gastrointestinal disturbances, nagging boredom, and a low-grade persistent depression.”²

There is usually a common core in the consequences of burnout: “a loss of concern, loss of feeling, a feeling of detachment, a tendency to treat others in a dehumanized way, ending in a feeling of utter hopelessness,”³ and “a progressive loss of ambition, idealism, energy, calling, and purpose.”⁴ For the minister, burnout can often mean the end of a career, the abandoning of a vocation.

Burnout, like stress, may be conducive to depression. In a way, it could be seen as an intermediate step between stress and depression. “We experience burnout not as the result of a major stressor, but from an accumulation of minor stressors,”⁵ or “a stressful situation over an extended period of time.”⁶

¹Oswald, 68.

²Sanford, 1.

³Beaven, 11.

⁴Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 113.

⁵Beaven, 12.

⁶Oswald, 57.

However, there are differences between the characteristics of burnout and stress. While stress involves the overuse of our adjustment capacities—too much transition, novelty, change—burnout involves the overuse of our listening and caring capacities—too many needy people, too much responsibility.¹ Other differences may include:²

1. Burnout is a defense mechanism characterized by disengagement; stress is characterized by overengagement.
2. In burnout the emotions become blunted; in stress, overreactive.
3. In burnout the damage is primarily emotional, in stress it is physical.
4. Burnout affects motivation and drive; stress affects physical energy.
5. Burnout produces demoralization; stress produces disintegration.
6. Burnout can be understood as a loss of ideals and hope; stress as loss of fuel and energy.

Depression that results from burnout “is characterized by apathy—a progressive emotional detachment from life in the face of increasing frustration.”³

As pastors, we need to be aware of the pitfalls that can provide breeding conditions for burnout in ministry to develop coping skills that will help us avoid them.

¹Ibid., 58.

²Archibald D. Hart, “Understanding Burnout,” *Theology News & Notes* (March 1984): 5-6.

³Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 114.

Causes of Depression

Depression may result from a number of causes. It is usually impossible to pinpoint a single dominant one since almost always a combination of factors work together and are responsible for it. Furthermore, a number of myths about depression—some widely accepted and even preached—make this an often misunderstood issue. Thus, from the very start it is important to keep in mind that:

It is *not* true, that depression always results from sin or a lack of faith in God, that all depression is caused by self-pity, that it is wrong for a Christian to ever be depressed, that depressed feelings can be removed permanently by spiritual exercises, that happiness is a choice, or that a ‘depressed Christian is a contradiction of terms.’¹

Instead, some of the causes may be genetic vulnerability, a developmental trauma, intense life stresses, physical illness, and environmental and/or social influences.²

Following the model presented by Dr. Gary Collins, I have divided these causes into two major categories: the genetic-biological-environmental causes, and the psychological-cognitive causes.³ Then, I have added an additional section on the emotional hazards of ministry, explaining why the role and tasks of a minister may make him/her especially vulnerable to depression.

Genetic-Biological and Environmental Causes

Depression often has a physical basis. According to Collins, “at the simplest level, we know that lack of sleep, insufficient exercise, the side effects of drugs, physical illness,

¹Collins, 106, italics in the original.

²Hales, 47.

³Collins, 106.

or improper diet can all lead to depression.”¹ Let us look at these and other physical and or environmental causes in more detail.

1. *Drug and alcohol abuse*: Alcoholics and drug abusers suffer high rates of depression. On the other hand, depressed individuals have a high incidence of substance abuse. Although nobody knows for sure which comes first, depression or drug use, this cycle of events takes a devastating toll on the physical and psychological well-being of the people affected by them.² Other drugs, such as medications for various medical problems, excessive caffeine, and tobacco also should be considered culprits of this vicious cycle.³

2. *Lack of sleep or rest, insufficient exercise, and improper diet*: Several authors mention lack of sleep, insufficient exercise, and improper diet as factors which can lead to depression. Hart refers to them in these terms:

There are many causes for physiological depression that can be avoided or controlled; for example, depressions that are the consequence of fatigue, stress, poor diet, or other abuse of the body. . . . The minister who seldom or never engages in physical exercise is inviting the onset of depression. The work of ministry is sedentary in nature. It therefore takes deliberate planning and determined effort to make physical exercise a part of the daily routine. Studies have shown conclusively that the lack of adequate physical conditioning can have many disastrous consequences—both physical and psychological.⁴

Ellen G. White had a lot to say regarding the influence of these factors on the physical and mental health. Talking about fresh air and exercise she noted, “I saw the

¹Ibid., 107.

²Hales, 54.

³Ibid., 52-53.

⁴Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 16.

beneficial influence of outdoor labor upon those of feeble vitality and depressed spirits, . . .

Their blood has become impure for want of fresh air and exercise.”¹ And one of her many references to the importance of a proper diet warns us that

precious talent has been lost to God’s cause through intemperance in eating. Many, while they do live, are thus deprived of half the vigor and strength of their faculties. The brain is oppressed because the stomach is burdened. Ministers, above all others, should economize the strength of brain and nerve. They should avoid all food or drink that has a tendency to irritate or excite the nerves. Excitement will be followed by depression. Over-indulgence will becloud the mind, and render thought difficult and confused.²

Referring specifically to the rest ministers need to experience, Spurgeon said, “Repose is as needful to the mind as sleep to the body. Our Sabbaths are our days of toil, and if we do not rest upon some other day we shall break down. Even the earth must lie fallow and have her Sabbath, and so must we.”³

On more than one occasion Jesus Himself underlined the importance of rest, and in addition to setting an example, He urged His disciples to do the same. One such occasion was after John the Baptist had been beheaded and his disciples had buried him. They told Jesus what had happened, and He saw their distress and pain, “He said to them, ‘Come with me by yourselves to a quiet place and get some rest’” (Mark 6:31).

¹Ellen G. White, *Testimonies for the Church*, 1:562.

²Ellen G. White, “Practical Thoughts for the Camp-Meetings,” *Second Advent Review and Sabbath Herald*, May 8, 1883, 1.

³Charles Spurgeon, quoted in Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 18.

3. *Monthly premenstrual syndrome and postpartum depression*: Many women experience depression as part of a monthly premenstrual syndrome (PMS) and some suffer postpartum depression (PPD) following childbirth.¹ “Roughly half of mothers experience ‘baby blues’ after delivery, but PPD is a major depressive episode that begins three to six months after delivery. It occurs in about one in ten mothers and it may last months or years.”²

4. *Physical illness*: Other diagnosable medical illnesses may account for a good percentage of depression. A study conducted on a large number of depressed patients in Canada found that roughly 34 percent of these patients had a medical illness which contributed significantly to their symptoms, and 18 percent had an illness that was entirely responsible for the psychiatric problem.³ But, we need to keep in mind that “*depression can often be the cause rather than the result of some of the other medical problems.*”⁴

5. *Neurochemical malfunctioning, brain tumors, glandular disorders, or postadrenalin depression*: Other physical influences, such as neurochemical malfunctioning, brain tumors, or glandular disorders (e.g., abnormal thyroid activity), are more complicated creators of depression.⁵ “An extensive research has linked depression

¹Carlson, 75.

²Quinn, 55.

³Ibid., 14.

⁴Ibid., 53, italics in the original.

⁵Collins, 107.

to brain chemistry that often can be altered by antidepressive drugs.”¹

Dr. Archibald Hart has suggested that Elijah’s depression—following his encounter with the prophets of Baal (1 Kgs 18-19)—was probably an example of the physiologically based “postadrenalin depression” that frequently comes to those who have recently had an emotional “high.”

Whenever the body has experienced a period of high adrenalin demand, such as coping with an emergency, public speaking, or meeting a deadline, the adrenal system becomes exhausted and switches off when the demand is over. . . . Most of us feel it as depression. It is the body’s way of demanding rest; it turns you off to all interests and saps you of energy so that you are forced into a period of recovery. During this time the adrenal glands and other important systems are rejuvenated. The longer your system has been in a state of demand or energy, the longer it will take for it to rejuvenate. . . . The older we get, the less resilient is our adrenal system and the more depressed we become after an adrenalin high.²

Dr. Hart suggests that after very busy and highly demanding weekends, ministers’ experience of this type of depression on Monday mornings is simply a “purely physiological response, but is often misunderstood and misinterpreted by the minister.”³ Instead of seeing it as a shutdown of the adrenal system after the excesses of adrenalin consumed over the weekend, ministers may “spiritualize the problem and attribute it to false causes, which in turn only compounds the misery of the experience.”⁴

Ellen G. White also refers to this type of depression. Writing to one of the pastors she advised:

¹Ibid.

²Archibald D. Hart, *Counseling the Depressed* (Dallas, TX: Word, 1987), 96-97.

³Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 19.

⁴Ibid.

The Lord would have you, my brother, reform in your method of labor, that you may have a well-balanced mind, a symmetrical character, and spiritual strength to counsel wisely. . . . You are almost constantly overtaxing both your physical and mental powers, because you allow yourself to feel too intensely. You have a vivid imagination, and put much intensity into your preaching, which keeps the mind on a constant strain The reaction is sure to come; for you do not know how to let yourself down gradually from such a strain, and the poor mortal body feels the wear. A corresponding depression follows the high pressure.¹

6. *Seasonal affective disorder*: The lack of light can cause depression in some people. A well-documented form of depression known as seasonal affective disorder usually occurs in the winter. “In Florida the incidence of this disorder is 1 percent, whereas in New York it is almost 5 percent. In the long, dark winters of Alaska, 9 percent of residents have severe depression, and 28 percent have moderate symptoms of depression.”² This has been categorized as an environmental phenomenon leading to depression.

7. *Poorly ventilated rooms*: An interesting quote from Ellen G. White’s writings introduces another environmental/physical factor which may lead to depression:

The effects produced by living in close, ill-ventilated rooms are these: The system becomes weak and unhealthy, the circulations depressed, the blood moves sluggishly through the system because it is not purified and vitalized by the pure invigorating air of heaven. The mind becomes depressed and gloomy, while the whole system is enervated, and fevers and other acute diseases are liable to be generated.³

¹Ellen G. White, *Evangelism* (Washington, DC: Review and Herald, 1946), 658.

²Carlson, 75.

³Ellen G. White, *Mind, Character, and Personality*, 2:483.

8. *Family history, environment, and genetics*: “Two-thirds of depressed patients have family members who have suffered depression. Although mild depression does not seem to be inherited, more serious forms run in families, and in major depression the link becomes clearly evident.”¹ An immediate biological relative of a depressed person has a 15 percent chance of developing depression, and grandchildren, nephews, and nieces have a 7 percent risk.²

Ellen G. Whits warns us that

if the mother is deprived of the care and comforts she should have, if she is allowed to exhaust her strength through overwork or through anxiety and gloom, her children will be robbed of the vital-force and of the mental elasticity and cheerful buoyancy they should inherit. Far better will it be to make the mother’s life bright and cheerful, to shield her from want, wearing labor, and depressing care, and let the children inherit good constitutions, so that they may battle their way through life with their own energetic strength.³

Researchers have identified genetic markers for manic depression on different chromosomes, but they have not found the specific gene or genes for any depressive disorder.⁴ But studies of twins support the claim that there is a genetic component to depression. “If one fraternal twin has major depression, the second one has about a 20 percent probability of having the same. When the twins are identical, the figure jumps to

¹Hales, 48.

²Ibid.

³Ellen G. White, *The Adventist Home* (Nashville, TN: Southern Publishing, 1952), 218.

⁴Hales, 48.

45 percent—clearly suggesting a genetic vulnerability.”¹ Furthermore, adoption studies also underscore the significance of genetics. “A child of a depressed parent who is adopted at birth into a family with no history of depression is three times more likely to become depressed than is a biological child of the adoptive family.”²

Research in the genetics and biochemistry of depression is complex, but it is moving at a rapid pace. “Scientists still do not know if depressed thinking causes biochemical changes or if a chemical imbalance in the brain causes the depression.”³ But the current thinking is that there is some connection among all of these factors and “the genetic and biochemical dysfunctions in depression are triggered by life events, including problems in the family in which a depressed individual grew up.”⁴

Psychological-Cognitive Causes

Developmental, psychological, interpersonal, spiritual, and other nonphysical influences may also be at the basis of depression, but it is important to notice here that it is not always easy to separate the physical from the nonphysical causes because of the interconnection of mind and body.

¹Carlson, 76.

²Hales, 48.

³Collins, 107.

⁴Quinn, 10.

1. *Early life experiences*: Some evidence suggests that childhood experiences can lead to depression later in life. Many years ago a researcher named Rene Spitz published a study of children who had been separated from their parents and raised in an institution.¹ Deprived of continuing and warm human contact with adults, these children showed apathy, poor health, and sadness indicative of depression that could continue later in life.

Developmental traumas of childhood, particularly the death of a parent at an early age, can increase susceptibility to depression.² Neglect, abuse, and separation from a parent because of illness or divorce can also trigger childhood depression and increase the risk of depression in adulthood.³

Depression is also likely when parents blatantly or subtly reject their children or when status-seeking families set unrealistically high standards that children are unable to meet. When standards are too high or too rigid, failure is almost inevitable and depression often follows.⁴ These experiences do not always lead to depression, but they may increase the likelihood of severe depression later in life.

2. *Marital and family problems*: In general, people involved in stable, close relationships are less likely to be depressed than those in troubled relationships, or even

¹Collins, 107.

²Hales, 48.

³Ibid.

⁴Collins, 108.

those who never married.¹ In adult women, the single most common trigger for major depression is an unhappy love relationship.² Indeed, marital problems may lead to high levels of stress and ultimately depression. “People who describe their marriages as being in trouble are 25 times more likely to be depressed than those in happy marriages.”³

Conway summarizes some of these problems as lack of communication and intimacy, unmet personal needs, and a lack of personal growth within the couple relationship.⁴

Family problems can be equally stressful. One or more small children in home, children whose behavior is not all that one hoped for, and the family going through critical stages—such as the youngest child going to school, adolescents and their identity search and rebellion against parental authority, children growing up and leaving home—may account for high peaks in the stress thermometer.⁵ Not to be forgotten is the extended family—their expectations and demands, aging parents, their health and/or distance issues, among others.

3. *Stress and significant losses*: As mentioned before, the stresses of life may stimulate depression, especially when these stressors make us feel threatened.⁶ The same

¹Kaelber, Moul, and Farmer, 24.

²Hales, 49.

³Ibid.

⁴Conway, 185-190.

⁵William E. Hulme, *Mid-Life Crises*, Christian Care Books, no. 7 (Philadelphia, PA: Westminster, 1980), 39-40.

⁶S. Folkman and R. S. Lazarus, “Stress Processes and Depressive Symptomatology,” *Journal of Abnormal Psychology* 95 (1986): 107-113.

applies to significant losses. The most traumatic losses are those that deprive us of people whom we love— namely the death of a parent, grandparent, friend, spouse, child, spontaneous miscarriage, and even an elective abortion. These can be extremely painful and are known to be among the most powerful depression-producing events of life.¹ However, moving, prolonged separations, divorce, and remarriage may also result in a significant sense of loss. Even the loss of a job, a prized possession, or a cherished dream may be painful and very stressful.²

“Not mourning or coming to terms with a loss can breed feelings of sadness and anger. With time, these emotions can fester into deep-rooted sense of unhappiness, low self-esteem, hopelessness, and extreme sensitivity to rejection.”³ This unresolved grief can increase the risk of depression.

4. *Learned helplessness*: One theory suggests that depression most often comes when we encounter situations over which we have little or no control.⁴ It is easier to become depressed when we learn that our actions are futile no matter how hard we try, or that nothing can be done to relieve our suffering, reach a goal, or bring about change. At such times we may feel helpless and give up trying. This could explain some of the depression in grieving people who can do nothing to bring back a loved one, in the student

¹Collins, 108.

²Ibid.

³Hales, 50.

⁴Martin E. P. Seligman, *Helplessness: On Depression, Development and Death* (San Francisco: Freeman, 1975), 145.

who is unable to relate to other students or succeed academically, or in the older person who is powerless to turn back the clock and restore lost physical capacities.¹ When such people are able to control at least a portion of their environments, depression may subside or disappear.

5. *Mid-life crisis*: Both men and women approaching mid-life have some difficult times ahead. In the case of men this period can be especially traumatic. “He has crossed a cultural barrier that influences the way he is viewed at work, by his family, and in society in general.”²

Although andropause does not bring about sudden biological events that cause these emotional changes—at least nothing comparable to the female menopause—men “do have some of the same feelings common to menopause—anxiety, irritability, fatigue, unhappiness with life, and the two major emotional feelings are self-pity and depression.”³

Dr. Hulme states that “men are most susceptible to depression in mid-life, when they become alarmed over the aging process or are unhappy in their work.”⁴ A person may experience a vocational crisis, or the sense of calling and personal fulfillment he derives from his workplace may seem to be collapsing under the weight of different factors. The pressures to keep up with new technologies in a knowledge explosion era,

¹Collins, 108.

²Conway, 19.

³Ibid., 20.

⁴Hulme and Hulme, 55.

the feeling of being caught between two generations, the world's cult of youth, all may influence this critical transitional stage.¹ In our culture, many men center their worth on their work. Failure, or fear of failure there, can be very frightening.²

Mid-life is also a time when marital and family problems are most likely to occur. Several of the critical stages mentioned in the section on the family occur during mid-life.³ The man in mid-life is caught between his adolescent children and his aging parents. Both demand extra time and attention at a time when he begins to realize that time is not eternal. Indeed, he begins to watch signs of decline with dismay, and since for most men physical fitness is very important this can be very disturbing. "They are challenged to come to terms with their mortality."⁴

Not every man/woman experiences a mid-life crisis, but in the best scenario some moments of sober reflection will occur, and the response to these may shape their remaining years.

6. *Cognitive causes or thought patterns*: How a person thinks often determines how he or she feels. This is a basic assumption of the cognitive views of depression. If we think negatively, for example, see only the dark side of life, maintain a pessimistic mindset, and overlook the positive, then depression is almost inevitable.

¹Conway, 45-58.

²Ibid., 57.

³Hulme, 39-40.

⁴Ibid., 57.

According to Aaron Beck, depressed people show negative thinking in three areas.¹ First, they view the world and life experiences negatively. Life is seen as a succession of burdens, obstacles, and defeats in a world that is “going down the drain.” Second, many depressed people have a negative view of themselves. They feel deficient, inadequate, unworthy, and incapable of performing adequately. This in turn can lead to self-blame, self-pity, and low self-esteem. Third, some people view the future in a negative way. Looking ahead they see continuing hardship, frustration, and hopelessness.

The inner thought processes of our minds are perhaps the greatest cause of depression. Researchers, scientists, and theologians are increasingly emphasizing this concept. Inability to forgive, self-pity, faulty and negative thinking, rigidity, inability to accept change, low self esteem—all are evidences of wrong choices in thinking and may result in self-imposed depression.²

7. *Anger*: An old and widely accepted viewpoint suggests that some depression comes when anger is held within and turned against oneself.³ Many children are raised in homes or sent to schools where the expression of anger is not tolerated, and sometimes the church condemns anger as a sin. “Some people are convinced that they should never even feel angry, so they deny hostile feelings when these do arise.”⁴

¹Aaron T. Beck et al., *Cognitive Therapy of Depression* (New York, NY: Guilford, 1979).

²Dianes, 12.

³Collins, 108-109.

⁴*Ibid.*, 109.

The idea that anger is a bad, sinful emotion has developed over many centuries. During this time many misunderstandings have developed. Some Christians believe that if you work at it (by counting to ten, praying without ceasing, or thinking positive thoughts), you can keep yourself from feeling angry. . . . The truth is that every human being experiences anger! It is a part of our human nature. God has created us this way! . . . Actually, Christians *should* get angry in response to certain situations (injustice, for example).¹

But anger needs to be recognized and expressed in positive ways to avoid destructive actions born from a desire of revenge, such as hostile humor, sexual misconduct, nagging, silence and withdrawal, or explosive and violent actions which can range anywhere from yelling, swearing, slamming doors or temper tantrums, to spouse and child abuse, mugging, rape, or murder.²

If not controlled, anger may be misdirected toward others, an innocent party—including God—and even fall in the category of “porcupine syndrome,” as Lester refers to people who are constantly angry.

They seem always on the verge of being mad. You would describe their daily life with words such as harsh, intolerant, demanding, quarrelsome, cruel, bitter, vengeful, and spiteful. . . . These people are basically insecure and the underlying anxiety keeps them in a constant state of defensiveness. Their alarm system is stuck in the “on” position, keeping them mobilized for attack at any time. In attempting to stay in control, they relate to people by “moving against.”³

On the other hand, if anger is misdirected toward the self and “pushed out of our minds, it festers ‘under cover’ and eventually affects us in some other way.”⁴ In those

¹Andrew D. Lester, *Coping with Your Anger: A Christian Guide* (Philadelphia, PA: Westminster, 1983), 16, 35.

²Ibid., 55-60.

³Ibid., 63.

⁴Collins, 109.

cases, anger may lead to psychosomatic symptoms—such as headaches, cardiovascular problems (high blood pressure), gastrointestinal disorders (ulcers and colitis), or many disorders of the skin—or to depression.¹

Ellen G. White talks about “the depressing and even ruinous effect of anger, discontent, selfishness, and impurity,” as opposed to the “marvelous life-giving power to be found in cheerfulness, unselfishness, and gratitude.”²

Indeed, depression may hide underlying hurt, anger, and resentment which in a depressed mood appears to be forgotten,³ but this accounts for only part of the problem.

8. *Sin and guilt*: We can easily understand why sin and guilt can lead to depression. When a person feels that he or she has failed or done something wrong, guilt arises and along with it comes self-condemnation, frustration, hopelessness, and other depressive symptoms.

God has so constituted us that guilt must be resolved. . . . We are concerned now, not simply with some overt guilty act, but with all that registers on the inner self as guilt: shame, inferiority, feelings of rejection and worthlessness, together with thoughts, desires, and impulses which we feel are “bad.” God has instituted divine forgiveness, and if our concept of God’s unconditional love is adequate, we can accept His pardon, and forgive ourselves. However, if we cannot believe in a God of infinite love and accept His forgiveness, then guilty feelings will persist in some form until they are resolved, one way or another.⁴

¹Lester, 61.

²Ellen G. White, *Education* (Mountain View, CA: Pacific Press, 1952), 197.

³Collins, 110.

⁴Cecil G. Osborne, *The Art of Understanding Yourself* (Grand Rapids, MI: Zondervan, 1967), 100.

According to Osborne,¹ there are several kinds of guilt which demand forgiveness. First of all is guilt before God for the violations of basic spiritual, ethical, or moral laws—as specified by God in the Bible. A second category is guilt before man, involving violations of a social ethic or taboo in a particular culture—this would include the laws established by one's society. Another category concerns false guilt. This refers to our feelings of guilt where there is no actual guilt, either of commission or omission. "This may persist through life in some diffused, indefinable form. The individual is not sure whether to call it a sense of guilt, inferiority, inadequacy, shame or alienation."² For example, a child whose parents set unrealistically high goals for him may thereafter feel that he can never quite measure up, and so he judges himself a failure, and feels vaguely guilty and unworthy. Because he was unacceptable to his parents, he becomes unacceptable to himself. The cause may have been continued parental displeasure over his grades or his failure to measure up to many adult demands and expectations. He may go through life with an ill-defined feeling of futility.³

Whatever the type of guilt, if we do not resolve guilt through the securing of God's forgiveness and our own self-forgiveness, an inner mechanism goes into operation. "We will suffer an inner dis-ease, in the form of remorse, depression or some other mental or emotional manifestation. When this becomes too great, the mind passes its pain on to

¹Ibid., 126-128.

²Ibid., 126-127.

³Ibid., 127.

the body, and actual organic disease can follow.”¹

Guilt and depression so often come together that it is difficult to determine which comes first. Probably in most cases guilt precedes depression, but sometimes depression will cause people to feel guilty (because they seem unable to ‘snap out’ of their despair).² “Whatever the case, a vicious cycle is set in motion. Guilt causes depression which causes more guilt, and the cycle continues.”³

It is important to emphasize once again here that although sin and guilt may sometimes trigger depression, depression is not a sin. Indeed, as we have seen depression can have many other causes other than these two. We all accept physical pain as a normal part of the human experience, but some devout Christians—including ministers—have problems accepting the fact that psychological or emotional pain is also just that, a normal part of the human experience.

Therefore, ideas such as “depression is the result of sin,” “all depression comes from Satan,” “depression is God’s punishment,” “depression is a sign that a person is not right with God,” “Christians should never be depressed,” “depression is generated by excessive self-pity” or “prayer can take away all depression” are “all misleading because they oversimplify the concept of depression, don’t allow that depression is a normal process, and create unrealistic expectations and self-rejection in the minds of those who

¹Ibid., 107.

²Collins, 109-110.

³Ibid., 110.

suffer depression.”¹ People who refer to depression in those terms completely miss the scope, magnitude, and multiple factors leading to depression.

The Emotional Hazards of Ministry

Most ministers have a high degree of emotional health. Although they experience trials, anxieties, and even occasional periods of discouragement, just as everyone else, they face their problems with courage and faith, and emerge from each crisis with a better understanding of themselves and others, and a closer relationship with God.²

But ministers are threatened by special health and psychological hazards.³ In addition to their sympathy for the suffering and desire to relieve human distress, pastors carry emotional burdens intrinsic to their “superior calling,” and many times they feel torn between the holiness of their vocation and personal feelings of unworthiness.

These and other factors may make them especially vulnerable to depression. An awareness of some of the pitfalls to be encountered in ministry may help clergymen to avoid them, and a better understanding of their nature may help those who have fallen into any of these to climb out of them.

The Nature of the Work

The work of the minister, when done in earnest, is bound to open the way to

¹Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 9.

²Ibid., 12-13.

³Ibid. See pp. 12-23 for a general overview of the emotional hazards of ministry that Hart presents.

periods of discouragement, and may lead to depression.

The weightiness of feeling responsible for the souls of others and of longing to see others experience the fullness of God's gift; the disappointment of seeing believers turn cold and pull away; the heartbreak of watching a married couple destroy each other, unable to utilize love and the grace of God in repairing their broken relationship—all will take their toll on sensitive and dedicated ministers.¹

Indeed, the work of a minister is demanding, slow, many times glorious but often discouraging. The minister may claim that his or her *modus operandi* has always been holistic, but being concerned for a person's physical, mental, emotional and spiritual well-being is an around-the-clock business. "This sets up certain demands on a minister, with the potential for stress which may not be present to such a degree in other vocations. The minister is thus set apart by the very nature of his or her calling."²

Furthermore, clergy are crisis people, and they are forced to make rapid transitions between joy and sorrow. They are involved "in the pains of life and the crises of life and death."³ A wedding may follow a funeral with only several hours' interval. The minister may be witness to or made a confidant of abuses, poverty, injustice, unemployment, conflicts, illness, and many other sad scenarios. And the faithful minister *feels* for every one of his/her parishioners. The apostle Paul expressed this beautifully in 2 Cor 11:28, 29: "Besides everything else, I face daily the pressure of my concern for all the churches. Who is weak, and I do not feel weak? Who is led into sin, and I do not inwardly burn?"

¹Ibid., 16-17.

²Daniel B. Leavitt, *A Faith for the Middle Years* (Washington, DC: Alban Institute, 1982), 14.

³Hulme, 2.

Continuous ministry in crises can deeply affect a person.¹ Indeed, this ministry of identification may take a high toll in the emotional welfare of the pastor.

The Demands and Expectations of Ministry

There are inept, ineffective, and even neglectful ministers, but most ministers are conscientious and trustworthy. The majority have a tendency to be compulsive workers.² A study of ministers in the Minneapolis, Minnesota, area, showed that 85 percent had problems with overwork,³ and only about 4 percent of the ministers had had specific training in time management.⁴ A study of Episcopal ministers found that the average work week for parish priests was 66.7 hours.⁵ Coates and Kistler found that the mean work week for Baptist ministers was 59.4 hours; for Episcopal ministers 62.4 hours; for Lutheran ministers 49.3 hours; for Methodist ministers 67.6 hours; and for Presbyterian ministers 76.9 hours.⁶ Dr. Alfonso Valenzuela, in his study of SDA ministers, found that

¹Several authors refer to the severe drain of energy involved in helping those in distress. Specially refer to *ibid.*, 2-3, and Sanford, 49-59.

²Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 13.

³Paul D. Robbins, "The Ministers of Minneapolis: A Study in Paradox," *Leadership* 1 (Winter 1980): 121.

⁴Richard Daniel Paul, "An Investigation and an Analysis, Leading to a Reassessment of the Minister's Attitudes Toward and Time Spent in Leisure Activities" (D.Min. dissertation, Drew University, 1980), 117-121.

⁵Episcopal Church, The Strategic Research Services Group of the Executive Council, *The Top Priority Empirical Research Project of the Clergy* (Darien, CT: Ecumenical Consultants, 1970).

⁶C. H. Coates and R. C. Kistler, "Role Dilemmas of Protestant Clergymen in a Metropolitan Community," *Review of Religious Research* 6 (1965): 147-152.

they worked an average of 56.25 hours per week.¹

Yet another study, conducted by Dr. David G. Congo, found that 85 percent of ministers spent two or fewer evenings per week at home, 70 percent worked more than 60 hours per week, 61 percent spent less than one hour per week talking to another pastor, 75 percent spent less than one evening per month socializing with other couples, and 40 percent did not take a regular day off.²

Among the specific demands and expectations of ministry that may result in a pattern of workaholism we may name the following:

1. *Unclear or confusing work boundaries*: The minister's work is immense and never ending. When is the task ever completed? No pastor can ever visit enough, pray enough, study enough, prepare enough sermons, baptize enough, or be involved in enough social issues.³ Ministers are always "on call," totally available to people—and they never have weekends off! "Even when a minister collapses exhausted into an easy chair at the end of a day, there is still a pervading sense of incompleteness that keeps the body's systems in a state of alertness and makes full relaxation impossible."⁴

There are no clear starting times or quitting times, and no limits to the seemingly infinite areas a pastor may—and sometimes is expected to—become involved in. In fact,

¹Valenzuela, 57.

²David G. Congo, "What Causes Burnout?" *Theology News & Notes*, March 1984, 7.

³Sanford, 5.

⁴Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 20-21.

this diversity of tasks in ministry may actually be one of its most attractive features,¹ but it can also lead to very high levels of stress.

Furthermore, there may be disagreement or conflicting opinions between church members, church officers, denominational leaders, community leaders, and the pastor as to the priorities of the many ‘hats’ he/she is expected to wear.² For instance, while church members may feel the pastor should spend most of his/her time visiting the members in their homes, church officers may feel he/she should be conducting more evangelistic efforts, and the pastor may believe that his main role is that of an educator—training and enabling people to do things for themselves.

Therefore, ministers must learn to prioritize and set specific objectives, taking into account his different roles: preacher, pastor, priest, counselor, teacher, organizer, fund raiser, relief agent, arbitrator, and administrator. They must break the work into smaller tasks, realistically estimated, in order to tackle them one at a time and experience some sense of accomplishment. Unless this is done, the job can become overwhelming. Indeed, “one of the major causes of stress disorders—including depression—is a chronic feeling of incompleteness and a pervasive anxiety about tasks still needing attention. This keeps the various systems in the body from switching off and returning to a relaxed, restful state.”³

¹Warlick, 33.

²Barbara G. Gilbert, *Who Ministers to Ministers?* (New York, NY: Alban Institute, 1992), 6.

³Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 118.

2. Internal control mechanisms and criteria for measuring work accomplishment:

Most ministers work on their own, and structure their own time. Although there is a certain degree of accountability to superiors, most ministers rely on internal control mechanisms which generally encourage a intense sense of responsibility.

The pastor must utilize characteristics of conscientiousness, honesty, and accountability to God to do his work; and, while these internal control mechanisms are sometimes effective in producing high levels of work output, they can also be more demanding and exacting than external controls. . . . As a consequence, the faithful, efficient minister in charge of a church often works harder and more conscientiously than most professionals in other occupations.¹

And, when does a pastor feel successful? When there is high attendance to church? When the tithes and offerings exceed expectations? When a predetermined number of new members join in a given period of time? Every experienced pastor knows how elusive and misleading such criteria can be.² “The demands placed upon the minister are so broad-ranging and omnipresent that it becomes impossible to satisfy them all. Thus, an element of failure is built into every minister’s role expectations.”³

Still, we usually find it difficult to experience a sense of accomplishment if we cannot measure and evaluate our progress. Thus, certain “proofs of success”—tangible goals and measurable objectives—have a place in helping us experience a certain sense of achievement. But we need to be careful not to exaggerate their role. Rather, we must “be in tune with God’s eternal criteria of success—faithfulness. . . . We are called to be

¹Ibid., 13.

²Sanford, 6-7.

³Leavitt, 14.

obedient, not successful, and any pastor who takes his eyes off the values God holds highest is bound to be prone to depression.”¹ After all, Noah, Jeremiah, and several other biblical characters could be judged as total failures if we were to measure them by the results of their “evangelistic efforts.” Indeed, faithfulness *is* success, regardless of how it may appear in the eyes of this world, and we, as ministers, would do well to remember this in our own experiences, and share this concept with those within our range of influence.

3. *Unrealistic expectations*: In addition to working harder, the average minister often struggles to live up to unrealistic expectations. Expectations are a blessing because they mean a person has given reason for confidence. In fact, expectations can energize and motivate a person, but if those expectations are unrealistic or impossibly idealistic, people may crumble under their weight.

Ministers occupy a position of high visibility, and they are often put on a pedestal by those around them. Such prominence involves certain hazards. One is pride; but even more difficult is the problem of living up to the expectations placed on their shoulders. Often they are expected to be better than everyone else, untroubled by the family, interpersonal and social problems of our days, and, of course, above reproach.² Baptist pastor and author Edward B. Bratcher says, “Many laypersons expect ministers to be 10

¹Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 120.

²Schoun, “The Minister as a Human Being,” 3.

feet tall and able to walk on water.”¹

Furthermore, they may have to deal with contradicting expectations from different groups of people—the congregation, superiors, colleagues, family, community, and their own—which can sometimes be the hardest ones to live up to.

Ministers often feel the need to be almost superhuman, possessing unusual gifts of intellect, social grace, and moral strength. They must be the perfect example of all the attributes of the Christian gospel. This is clearly an impossible situation, but many find themselves caught up in an endless cycle of attempting—and failing—to live up to these demands.²

And because of the high visibility, people know when they fail. “Depression in the minister can be a direct result of failing to live up to the expectations the pedestal position creates.”³ Or it can be a result of the constant struggle to maintain that position. A discrepancy between the reality and the expectations—internal or external—may “fuel feelings of inadequacy, poor self-image, hypocrisy, and the fear of being discovered.”⁴

Although there is value in maintaining high standards, it is imperative that ministers acknowledge their humanness and learn to accept the limits of their frailty. Without minimizing the excellency of the ministerial call, they have to accept that “the human nature of ministers is not different from that of all other persons. They are basically as

¹Edward B. Bratcher, *The Walk-on-Water Syndrome* (Waco, TX: Word, 1984), 22.

²*Ibid.*, 13-14.

³*Ibid.*, 121.

⁴Schoun, *Helping Pastors Cope*, 32.

weak as any other, while others can be as strong as the minister.”¹ Indeed, their human nature is presented many times in the Scriptures. Isaiah the prophet acknowledged his weakness (Isa 6:5), Jeremiah expressed his vulnerabilities (Jer 20:18), and Paul left no doubts about his humanity and shortcomings (Acts 14:15; Acts 15:36-39; 1 Tim 1:15; Rom 7:15-25; 2 Cor 4:7; 12:9,10).² Hebrews speaks of a high priest who “is able to deal gently with those who are ignorant and are going astray, since he himself is subject to weakness. This is why he has to offer sacrifices for his own sins, as well as for the sins of the people” (Heb 5:2, 3). And Jesus Himself, although without sin, made Himself vulnerable to be “able to help those who are being tempted” (Heb 2:18).³

It is when a minister denies his limitations that he overworks, sets himself up with unrealistic expectations, neglects his family, and gets discouraged, if not ill. . . . We demonstrate our creatureliness by living within the limits of our humanity and accepting the help that our weaknesses require.⁴

Therefore, we need not fear our own vulnerabilities and limitations. Instead, we should learn to live with them, developing the talents the Lord has given us, and making the best possible use of the challenging opportunities we have of helping others.

4. *Ministry is people oriented:* Ministry is first and above all a people-oriented profession, and whenever people work with people, there will be misunderstandings and problems of communication. In no other profession, though, can the effects of these be as

¹Ibid., 70.

²Ibid.

³Ibid., 73.

⁴Ibid., 75.

damaging as in ministry. Dr. Hart suggests two reasons for this.¹

First, ministers are generally not as well trained in handling conflict, difficult personalities, and communication problems as other helping professions—such as social workers, psychologists, or counselors. Seminaries place most of their emphasis on theological study and preaching, and by the time a young minister realizes he or she has problems relating to people, problems may already have become heavy burdens to him/her.

Second, ministers relate to people in a voluntary structure. Church congregations choose to be there, and they can decide not to be. In fact, some church members participate when they like how things are going and disappear when problems develop or if they disagree with the leadership style of the minister.² But this is simply the nature of work with volunteer organizations, and God's church is a unique institution in which everyone has equal status and value. In Scripture it is compared to a body with many parts. "Getting the parts of this body to work well together is challenging and immensely satisfying work, but it is also extremely difficult."³

Loneliness, Solitude, and Isolation

The minister often finds himself/herself standing apart from his/her congregation. There may be conflict or privileged information keeping the pastor from getting close to

¹Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 115-117.

²Robert Trujillo, "Job Stress and Strain in the Parish Ministry" (Ph.D. dissertation, University of Michigan, 1984), 25.

³Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 116.

the people, or he/she may want to avoid being accused of taking sides if he/she develops closer friends. The minister may also feel that becoming too close erodes authority and respect. Indeed, a leadership role tends to set one apart no matter what the vocation, but a minister will find this especially true.

The pastor's life is marked by a type of loneliness which is peculiar to those who receive their calling from God. It is a solitude of sacredness, an isolation of the soul that feels the responsibility of eternal issues and must maintain its commitment to divine purposes above all else.¹

This kind of loneliness—which I prefer to call solitude and is not necessarily physical isolation—serves a purpose. It “helps the pastor stand above the petty parochial interests of people who have too much investment in the here and now, and helps to keep the call and demands of the kingdom of God in the foreground.”²

Furthermore, the solitude that comes from “an exploration of that inner relationship with God where ministry has its roots”³ is highly desirable. In his book *Ministry and Solitude*, James C. Fenhagen shares some deep thoughts on this matter.

Christian ministry is more than doing good. . . . Ministry is Jesus Christ expressing his life through us. It is born, therefore, not in activity, but in solitude, where through the Spirit we experience the power of life from within. No one becomes a “minister.” Rather in trust we so open ourselves to the Spirit that Jesus Christ can express his ministry through us. Prayer and ministry, therefore, are indissoluble. In the stillness

¹Ibid., 17.

²Ibid.

³James C. Fenhagen, *Ministry and Solitude* (New York, NY: Seabury, 1981), x.

of meditative prayer we are confronted by God's loving claim upon us—the most intense intimacy a human being can experience.¹

This intimacy—the source of spiritual life, spiritual growth, and divine power—needs to be cultivated and provides the positive side of loneliness. Unfortunately, our efforts to fill our lives with activities many times leave us with little time or space to nurture this relationship with Jesus.

To be alert ministers involves friendship with solitude, a knowledge of that center within ourselves where intimacy with God is deepest and we can see the world—if only momentarily—through the eyes of Christ. Growth in the Spirit, therefore, requires the time and effort and openness to become a person of serious and consistent prayer.²

But loneliness may also be “a defense mechanism against unresolved developmental needs, i.e., independence, authority, and control.”³ The minister may be “afraid that if he permits anyone to get too close to him that person will find out he really can't walk on water.”⁴ This unhealthy isolation from those around us can cut the minister off from support systems; it can keep him from having close confidants with whom problems of the work can be discussed.

It is a psychological fact that one cannot resolve conflicts or clarify issues simply by thinking about them. Self-talk and introspective rumination with no outside input lead inevitably to distortion and irrationality, whereas talking things over with someone else can help to clarify issues and remove distortions. Every minister needs close confidants—staff, family, other ministers, trusted laypersons in the congregation—to help in this clarifying process. If steps are not deliberately taken to

¹Ibid., 9.

²Ibid., 60.

³Louis McBurney, *Every Pastor Needs a Pastor* (Waco, TX: Word, 1977), 61-63.

⁴Bratcher, 30.

develop these trusting and supportive relationships in each pastorate, the loneliness of leadership responsibility will lead to isolation and a distortion of reasoning—and this spells depression for many ministers.¹

Frequent moves may be another factor stirring feelings of loneliness and isolation. They prevent the minister and his/her family from developing close ties and firm roots. “Moving means losing relationships which have become important to the pastor and the family.”² In fact, the increased mobility the clergy family experiences is often cited as one of the major stressors in the lives of the minister and his family.³

Dennis Doyle reports that 93 percent of the ministers involved in his survey had experienced feelings of loneliness and isolation.⁴ Of the ministers surveyed in Minneapolis, 67 percent acknowledged these feelings,⁵ and in a study of SDA ministers, 58 percent reported that they sometimes feel lonely and isolated.⁶ Paul felt lonely and longed for the comfort of friends (2 Tim 1:3,4). Even Jesus retreated to the home of His friends when He needed to get away. At the home of Martha, Maria, and Lazarus He found rest and support. “There he kicked off his sandals and slept in a bed—a rarity for

¹Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 18.

²Enos D. Martin, “Depression in the Clergy,” *Leadership* 3 (Winter 1982): 81-82.

³Thomas C. McGinnis, “Clergymen in Conflict,” *Pastoral Psychology* 20 (October 1969): 14.

⁴Dennis Lee Doyle, “Annual Study Leave as a Means of Reducing Pastoral Dysfunction” (D.Min. dissertation, Southern Baptist Theological Seminary, 1977), 26.

⁵Robbins, 121.

⁶Roger L. Dudley, Des Cummings, Jr., and Greg Clark, *The Pastor as Person and Husband: A Study of Pastoral Morale* (Berrien Springs, MI: Institute of Church Ministry, 1981), 5.

him. Martha laundered his dusty robe and served up a home-cooked meal.”¹ And during His most difficult moments on earth, Jesus sought and begged His disciples to pray with Him and keep Him company (Matt 26:36-41).

The truth of the matter is that when ministers need a friend or are in trouble they do not know whom to turn to. They may not dare to go to an ecclesiastical superior who holds their career in his/her hands. They may also fear to confide in their peers. Studies have shown that ministers often look at their peers not as colleagues but as competitors.² Many pastors find their greatest support from their spouses, and this is perfectly natural, but many times this is not enough. “Clergy persons without at least one good friend in ministry with whom they can be utterly honest about their deepest feelings walk a very lonely road.”³ Fortunate is the minister who finds such a friend!

Time pressures, role conflicts, and other factors may also play a part in feelings of loneliness, and the lack of a support network of friends and people we trust, but these need to be overcome. As pastors we need to understand the importance of friendships to our physical and emotional health.

Narrowing of the Minister's Focus

Many aspects of ministry can cause ministers' lives to become too narrow.

¹Lavender, 52.

²Paul W. Turner, “The Minister's View of the Ministry,” *Search* 2, no. 4 (Summer 1972): 35.

³Ray W. Ragsdale, *The Mid-Life Crises of a Minister* (Waco, TX: Word, 1978), 24.

The work can be so consuming that it becomes the single purpose for living, leading ministers to avoid all other interests and become so narrowly focused on their work that they lose a sense of balance. They may get so lost in the present challenges that they lose sight of their broader goals and miss the larger picture. Such attitudes result in a conflict of priorities, and the ministers' health and families are the first to suffer.

The minister's work should be important—even central—in his or her life. But, “when it so distorts priorities that the minister neglects to care for his or her own person and to give sufficient time to his or her family, singleness of purpose can lead to depression.”¹

Confusing Role Identity with Self-Image

Although low self-esteem was mentioned before among the cognitive causes of depression, it is important to highlight a few additional aspects of it in the context of the ministry.

There is a strong tendency for ministers to derive their self-image and thus their self-esteem from their vocational role. In other words, who they *are* is determined by what they *do*. Self-identity easily merges with role identity, so that it becomes increasingly difficult for ministers to separate themselves from their work and from the many roles they play as pastors.²

As a result, if they are successful in their work, they feel good about themselves, but if they experience some failure, they feel bad about themselves.

¹Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 21-22.

²*Ibid.*, 22, italics in the original.

His vocation becomes his sole source of emotional security, i.e., the fulfillment of his wishes for prestige, self-respect and the respect of society. For anyone so entirely wrapped up in his vocation, any failure in his work becomes an intensely personal failure—with attendant emotional distress.¹

Dealing with failure is never easy, but it would seem that it is even more difficult for pastors. The very notion of it leads pastors to struggles of self-worth, inadequacy, and personal value. It would appear that the theology of the “call” does not prepare ministers for failure.² “Failure prompts questions of meaning: Am I making a difference? What did I really accomplish?”³ And although most pastors are sensitive and forgiving of their members’ failures, and are very good at helping them put their defeats in proper perspective, they have problems doing the same with their own mistakes.

We understand grace, especially as it relates to others, but regrettably we are reluctant to partake of it ourselves, especially when it comes to some public mistake made in the actual practice of our ministry. Ministers are notorious for engaging in torturous introspection and self-flagellation. Why did I do it that way? How could I be so stupid? When am I ever going to learn?⁴

Furthermore, since ministry is a team effort which involves many others for a successful operation, i.e. laity support, whether pastors succeed or not does not depend entirely upon themselves.

On the other hand, ministry is a multiphasic work, and even though the pastor may

¹John Kildahl, “The Hazards of High Callings,” in *The Minister’s Own Mental Health*, ed. Wayne E. Oates (Great Neck, NY: Channel, 1961), 203.

²Fredrick A. Russell, “Failure: Getting Through the Inevitable,” *Ministry*, September 1998, 5.

³Ibid.

⁴Ibid., 6.

be very well fitted and exceedingly successful in some areas he/she may be lacking in others. An interesting study conducted by Samuel Blizzard¹ found that the personality traits, styles of leadership, and skills required for effective preaching were inherently conflicting with those needed to perform competently as a pastor/priest/ counselor.

Blizzard also contrasted the minister's role as a scholar with his traditional role as a "man of action." Smith corroborated this in a study conducted in 1973 in which he noted that while it is "rare for an individual to possess both the skills required for scholarly contemplation as well as those needed in decisive administration, almost every congregation expects both of its minister."²

Therefore, "ministers who let their feelings about themselves depend on the success in their work are inviting depression. There must be a clear boundary between what the self *is* and what the self *does*, if one is to be mentally healthy."³

Indeed, God expects us "to derive our self-worth from the knowledge that we are His redeemed children, not from whether we are successful in our jobs. Confusing self-image and role identity only gets in the way of God's power to work through us in any vocational situation."⁴

¹Samuel W. Blizzard, "The Minister's Dilemma," *The Christian Century* 8 (1956): 508-509.

²D. P. Smith, *Clergy in the Crossfire: Coping with Role Conflicts in the Ministry* (Philadelphia, PA: Westminster, 1973), 6-7.

³Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 22, italics in the original.

⁴Ibid.

The Minister's Family

Family problems were mentioned before as one of the causes of depression, but because ministry involves the whole family in such a distinctive way, a few additional comments need to be added here.

The minister's family also experiences the "pedestal syndrome." The whole family is on display and if one of them does not comply with the many expectations the congregation—or the minister himself/herself—may place on them, there is a high potential for conflict and resentment. In fact, ministers need a supportive family to "set a good example for the congregation." And in a subtle way, requesting, expecting, and even pressuring their families' involvement in their ministry may be a mixture of love and self-preservation since they depend on them for their own professional success. This pressure placed on the family "may lead to anger in the spouse and children, which can in turn block communication and promote strained relationships."¹

Loneliness and social isolation are among the most prevalent themes mentioned among clergy wives' negative experiences. "Ministers' wives consistently express a desire for close friends with whom they can be honest and open and with whom they can share the emotional burdens of the ministry."²

Furthermore, wives have usually received less specialized training for the roles expected of them, and many times they resent the lack of identity and space they have to

¹Bratcher, 88.

²Cameron Lee and Jack Balswick, *Life in a Glass House* (Grand Rapids, MI: Zondervan, 1989), 149.

be themselves.¹ They may have had to suppress vocational and recreational interests in order to meet the demands of their informal role as “associate” ministers.² And, in spite of working alongside their husbands, hardly ever do they receive monetary compensation or recognition. Furthermore, they seem to be criticized no matter what they do. One minister’s wife put it this way: “If a wife does too much, she is ‘running things,’ and if she is quiet and reserved, she is not doing her share and fulfilling her role as pastor’s wife.”³

Children, on the other hand, are measured by higher standards than other kids, and they are expected to be “role models” for the other kids in church. “There is a confusion of boundaries between public and private life, e.g., the minister’s home is sometimes treated as public domain.”⁴

But neglect and lack of enough time to spend with the family seem to be the most frequently mentioned issues in the minister’s family. “Pastors are under so much pressure from themselves and the congregations that they are tempted to deny their families the time that is rightfully theirs.”⁵ In Lee and Balswick’s study of clergy families, by far the

¹David Martin, “Forgotten Members: The Pastor’s Family,” in *Growth in Ministry*, ed. Thomas E. Kadel (Philadelphia: Fortress Press, 1980), 141-142.

²Trujillo, 22.

³Gilbert, 10.

⁴Schoun, *Helping Pastors Cope*, 34.

⁵Bratcher, 94.

most common response to what was the greatest disadvantage of being in the ministry was that “clergy families do not have enough time together.”¹ Ministers’ busy schedules does not allow for enough time with the family and the peculiarities of ministers’ schedule take away the times most families would spend together—weekends and evenings.²

A survey of 157 Adventist ministers’ wives throughout North America revealed many lonely and disillusioned wives. When asked how they saw their husband’s priorities, the average rating was: (1) church work, (2) time with God (3) his health, (4) wife, and (5) children. Nearly two-thirds of the wives reported that their husbands spent fewer than two hours per day—including mealtimes—with the family.³

A second phase of the survey revealed that 37 percent of the wives felt guilty about taking their husbands’ time to meet their own personal needs, 58 percent worried about the needs of others having priority over the needs of the family, 63 percent worried about their adequacy as pastors’ wives, 67 percent experienced loneliness and isolation, and 72 percent worried about not having enough family time.⁴

David and Vera Mace, leaders in the field of marriage counseling, present a list of

¹Lee and Balswick, 191.

²Ibid.

³Roger L. Dudley and Carole Luke Kilcher, “A New View of the Pastor’s Wife,” *Ministry*, June 1981, 28-29.

⁴Carole Luke Kilcher et al., “Morale in Ministry—A Study of the Pastor’s Wife as a Person,” *Ministry*, February 1982, 22-25.

disadvantages of clergy marriage extracted from surveys of ministers and their wives.¹ (Fortunately, they also present advantages which are referred to in Chapter 5). Among the most frequent responses were: marriage expected to be model of perfection, time pressures due to husband's heavy schedule, and lack of family privacy or "goldfish bowl syndrome." The list also includes: financial stress—wife must seek job outside to make ends meet, no in-depth sharing with other church couples, children expected to model church's expectations, husband serving others neglects own family, unfair criticism from church members, confusion about wife's identity and roles, dissatisfaction with housing arrangements, and frequent moves, i.e., no permanent roots.

Dr. Schoun refers to an informal telephone survey that D. W. Holbrook, then Director of Home and Family Service of the General Conference of SDA, conducted among a dozen church administrators.² Answering the question, "Where do you spend most of your time?" all but one said "dealing with personnel problems involving a variety of difficulties with pastors, their wives and children." Holbrook added: "We have identified as the number one problem among pastoral couples resentment and anger on the part of the wife because of the role she has to play and the difficulty the pastor has in understanding the problem."³ Many additional studies shed further light into this matter,

¹David Mace and Vera Mace, *What's Happening to Clergy Marriages?* (Nashville: Abingdon, 1980), 37.

²Schoun, *Helping Pastors Cope*, 35-36. This was extracted from a personal letter from D. W. Holbrook to Benjamin Schoun, dated April 10, 1981.

³Ibid.

and provide valid suggestions to strengthen the minister's marriage and family.¹

Financial Issues

A pamphlet issued by the U.S. Department of Labor, Bureau of Labor Statistics, presented a study on the relationship between the level of education and the remuneration of 432 occupations.² Though pastors ranked among the ten top occupations educationally—together with lawyers, physicians, dentists, judges, college professors, engineers, etc.—they ranked number 316 in the remuneration scale, in the same category of unskilled labor—library attendants, waiters, cooks, farm laborers, and file clerks. The 107 below their earning rank had not graduated from high school, and many had not gone beyond the eighth grade.

Even more disturbing, the clergy showed “the lowest percentage of salary increase among their professional peers in a ten-year period.”³ Although these data are not very recent financial pressures are still an issue among ministers. In his study of SDA ministers, Dr. Valenzuela found that “the number one reason Adventist ministers would consider leaving the ministry was because of finances; and not having enough money was the major

¹See Gilbert; Hart, *Coping with Depression in the Ministry and Other Helping Professions*; Mace and Mace; Alfonso Valenzuela, “The Minister's Personal and Family Life” (D.Min. Dissertation, Fuller Theological Seminary, 1989); idem, “An Ecosystemic Analysis of Marital Satisfaction in Seventh-day Adventist Clergy Families”; and Donald P. Troost, “The Minister's Family—People without a Pastor,” *Reformed Review* 31 (Winter 1978): 75-78.

²Dixie Sommers, “Occupational Ranking for Men and Women by Earnings,” in *Monthly Labor Review* (Washington, DC: Department of Labor, Bureau of Labor Statistics, August 1974), 34-51.

³Lavender, 74.

area of family stress.”¹

Even though SDA ministers are discouraged from having other sources of income, to avoid financial problems many find ways to earn additional money. These may include writing books and articles, seminars or speech engagements, translating or editing commitments, and other income producing activities. Very often their wives must also work. According to a study conducted in the U.S. in the seventies, while 42 percent of married women in the general population worked, 45 percent of clergymen’s wives were employed, and two-thirds of these because of economic necessity.²

Probably very few pastors enter the ministry in order to make money, and most are satisfied simply with the spiritual rewards of their work, but the weight of their financial struggles and/or debts may be very heavy and may push ministers to higher levels of stress, preventing them from carrying out a more effective ministry.

Consequences of Depression

Depression may have different effects on those suffering from it. These may include feelings of hopelessness, sadness, lack of energy, indecisiveness, and self-criticism. Life of depressed people is therefore characterized “by inefficiency, underachievement, and an increased dependence on others.”³ But if depression lingers for longer periods and is not properly treated, its consequences can grow in intensity and seriousness.

¹Valenzuela, “An Ecosystemic Analysis of Marital Satisfaction in Seventh-day Adventist Clergy Families,” 58.

²Ibid., 75.

³Collins, 110.

Physical Illness

Depression tends to suppress the body's immune system. As a result, the individual is more susceptible to illness and the body is less able to fight viruses and other diseases. Depressed people, therefore, are more likely than others to get sick.¹

Indeed, Ellen G. White also cautioned us about this:

The condition of the mind affects the health to a far greater degree than many realize. Many of the diseases from which men suffer are the result of mental depression. Grief, anxiety, discontent, remorse, guilt, distrust, all tend to break down the life forces and to invite decay and death.²

Crisis of Meaning and Leaving the Ministry

When a person is discouraged and unmotivated there often is low self-esteem, self-pity, a lack of self-confidence, and the strong desire to get away from other people. Social contacts may be too demanding and the depressed person may not feel like communicating. Instead, the individual may daydream of finding a simpler job.³

Although depression is not the only reason because of which ministers leave the ministry, it is certainly one of them. Several authors refer to ministers leaving their jobs as "a run-away epidemic."⁴ An interesting study among 370 ex-pastors of several Protestant

¹Tbid.

²Ellen G. White, *Ministry of Healing* (Mountain View, CA: Pacific Press, 1942), 241-244.

³Collins, 110.

⁴Vernon Grounds, "The Highs and Lows of Ministry," in *Your Better Self: Christianity, Psychology and Self-Esteem*, ed. Craig W. Ellison (San Francisco: Harper & Row, 1983), 189.

denominations¹ gives insightful information into the particular struggles and problems that led them to abandon their vocation. The ex-pastors were mainly clustered in the middle-age group from 35 to 48 years (49.9%) with 34.6 percent placed in the 34-and-under age group.² Over 50 percent had served as ministers from four to twelve years and had held two to four positions.³ Among the reasons given for leaving the ministry, the dominant ones were: a sense of personal and professional inadequacy (17.1%), problems with wife and children (13.2%), and personal illness or mental breakdown (8.5%).⁴

Other studies show the percentages grow much larger if we consider those who “have given serious consideration to leaving the parish ministry.” Close to 50 percent of the respondents in a national survey of Episcopal parish clergymen answered positively to this item.⁵ A 1983 Gallup survey indicated that 29 percent of American clergy have “often” or “occasionally” considered quitting the ministry because of frustrations or disappointments,⁶ and Newman reports that on a survey in one conference of Seventh-day Adventists, 40 percent of the ministers had considered leaving the ministry.⁷

¹Gerald Jud, Edgar W. Mills, Jr., and Genevieve Walters Burch, *Ex-Pastors; Why Men Leave the Parish Ministry* (Philadelphia, PA: Pilgrim, 1970).

²*Ibid.*, 45.

³*Ibid.*, 47.

⁴*Ibid.*, 50.

⁵J. A. Reimer et al., “The Problems of the Priest—Have His Concerns Become the Church’s Crisis?” *Review of Religious Research* 62 (1971): 186-187.

⁶Quoted in Valenzuela, “The Minister’s Personal and Family Live,” 42.

⁷J. David Newman, “Task Force Recommends Pay Hike,” *Ministry*, November 1988, 8.

Further studies showing probable connections between depression and the decision to leave the ministry would undoubtedly prove very beneficial.

Effect on Those Close to the Depressed Person

Depression affects not only the individual sufferer but all the people with whom he or she is involved—friends, relatives, employers.¹ A spouse's depression can be withstood out of love, concern or even guilt, but even in the best scenario a persistent recurrent depression can be very hard on relationships. It can disrupt and disorganize family life, and in many cases lead to divorce.² Furthermore, since relatives of depressed people—as seen previously—may be genetically or environmentally more predisposed to depression, the problem may be compounded.

Therefore, it is crucial that family members, friends, and people close to a depressed person learn more about the disease and find ways to support and encourage the depressed person, making this, instead of a devastating and disintegrating experience, one of individual and family growth.

Suicide

Many depressed people never consider suicide, but others do, often in a sincere attempt to kill themselves and escape life. When people try to kill themselves, their thinking at the time is usually not logical. It may be clouded by anxiety and hopelessness.³

¹Klein and Wender, 71.

²Ibid., 120.

³Collins, 477.

Writing under the pseudonym of Peter Mariner, an Adventist minister wrote a candid article on the hopeless feeling of depression. He confessed:

And then came a day of crisis. I was driving to make a pastoral visit—and I was in agony. Every worry beat upon me at once. The grief was palpable; it was as though I was impaled on a knife. I turned into a store parking lot, put my head back on the seat, and thought, *Forgive me, Lord, but I cannot live like this any longer. I think I am going to have to end my life.* I had no means at hand to do so but I would have to think of a way.¹

Most frequently, suicide attempts are an unconscious cry for help, a desperate way to escape what they perceive as a hopeless future, a way of avoiding problems that have become impossibly unbearable, an opportunity for revenge, or a manipulative gesture designed to influence some person who is close emotionally.²

It is commonly thought that people who consider or talk about suicide do not actually take their own lives, but *this is not true*, and although suicide attempts are not so frequent among ministers, they do occur.³

Suicide is an increasing epidemic in the United States. It is the eighth leading cause of death in adults and the second in children and adolescents, claiming over 30,000 lives a year according to the U.S. Bureau of the Census.⁴ For White men between the ages of 10 and 55, suicide is the fifth highest cause of death.⁵

¹Mariner, 25, italics in the original.

²Collins, 110.

³Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 80.

⁴Quoted in Klein and Wender, 5.

⁵Dana Charry, *Mental Health Skills for Clergy* (Valley Forge, CA: Judson, 1981), 57.

While some suicide attempts are blatantly clear (as when a man leaves a note and shoots himself), others are more subtle and may look like accidents. Some people carefully plan their self-destructive actions, others drive recklessly, or find other ways to flirt with death. "Because many suicides are disguised as accidents, it may be the number one cause of teenage death. Since the 1950s the number of suicides among youth has tripled."¹ Furthermore, it has been estimated that from eight to ten people attempt suicide for every one who commits it. This could mean that around a quarter of a million people in the United States alone attempt suicide each year.² Many public health experts consider that these figures are still very low, giving conservative figures of as many as 400,000 children and teenagers alone who try to kill themselves and fail each year.³

Since most of the cases of suicide are related to episodes of depression, they illustrate in a tragically vivid way the pervasive and potentially destructive influence of depression.⁴ Suicides are associated with feelings of despair, hopelessness, failure to live up to expectations, and deep sadness, which characterize depression. In fact, "suicide happens in the context of a depression that lingers and becomes difficult to overcome. It seldom, if ever, is isolated from the gloom of a mood disorder."⁵ It is estimated that

¹Diane E. Papalia and Sally Wendkos Old, *Human Development* (New York: McGraw-Hill, 1992), 546.

²Bootzin, Acocella, and Alloy, 261.

³Papalia and Old, 546.

⁴Collins, 110

⁵Baker and Nester, 178.

between 10 and 30 percent of depressed people eventually make a fatal attempt.¹

Twice as many singles as married people kill themselves, with young persons who have been widowed at the highest suicide rate. Three times as many women as men attempt suicide, but three times as many men as women actually succeed in killing themselves due to their use of more lethal methods. Whites are almost twice as likely to kill themselves as Blacks or Hispanics. And specially at risk are the unemployed and people in the helping professions—medical doctors being the highest at risk.²

Indeed, suicide is the ultimate act of rejection, ending a person's life and shattering many others since the effects of suicide can be excruciating on those left behind: parents, spouse, children, siblings, friends, colleagues, neighbors. As they mourn for their loved one, they may be haunted by regrets, questions, and "if onlys." Detecting depression in its early stages may allow the person to break out of the downward spiral and avoid the painful consequence of depression.

¹Ibid.

²Papalia and Old, 546-547.

CHAPTER IV

A SURVEY ON DEPRESSION

This chapter describes the instruments, subjects, and research procedure, analyzing the results of the two questionnaires mailed to the Hispanic SDA ministers in order to assess the scope of this problem among the chosen population.

The Instruments

The Zung Self-rating Depression Scale (ZSDS or SDS)

This is a short, reliable, and widely used cross-cultural survey/scale for the quantitative measurement of depressive symptomatology in adults. It comprises a list of twenty items, rated on a four-point scale, each of them related to a specific characteristic of depression.¹ All together they provide a comprehensive picture of the symptoms of depression as they are widely recognized.² The statements in the questionnaire are worded in everyday language, and certain safeguards were incorporated in their construction. Because half of the statements are worded positively and half negatively,

¹R. G. Knight et al., "Some Norms and Reliability Data for the State—Trait Anxiety Inventory and the Zung Self-rating Depression Scale," *British Journal of Clinical Psychology* 22 (November 1983): 245.

²Oscar K. Buros, ed., *The Seventh Mental Measurements Yearbook* (Highland Park, NJ: Gryphon, 1972), 136.

it is difficult for the person being tested to discern a trend in the answers.

A duplicate yellow sheet enables the person to self-rate his/her scores on the depression scale and to find out his/her level of depressive symptomatology. For this study, however, these duplicate pages were kept and used to rate the questionnaires as they were mailed back by the participants.

By using a conversion table—from Raw Scores to SDS Index—the total scores are translated into percentages of depression measurable by the scale. The SDS Index can be interpreted as shown in table 1.

The interpretation of the data—which compares depressed versus nondepressed subjects—does not in itself constitute a diagnosis but rather identifies the presence of symptoms that may be of clinical significance.¹ So, although “the SDS is intended to rate

Table 1. Conversion Table from Raw Scores to SDS Index

SDS INDEX	EQUIVALENT CLINICAL GLOBAL IMPRESSIONS
Below 50	Within normal range, no psychopathology
50-59	Presence of minimal to mild depression
60-69	Presence of moderate to marked depression
70 and over	Presence of severe to extreme depression

¹William W. K. Zung, “A Self-rating Depression Scale” *Archives of General Psychiatry* 12 (1965): 63-70.

depression as a disorder, it is not intended to differentiate among the different types of depression. It serves rather to quantitatively measure the intensity of depression, regardless of the diagnostic label used.”¹

A number of reports confirm the validity and reliability of the SDS on the basis of research performed in the United States and abroad.² Buross affirms that

scores on the SDS to differentiate depressive patients from those with other psychiatric disorders, are significantly correlated (.43 to .65) with global ratings of depression made by psychiatrists in the United States and six other countries, and are significantly correlated (.59 to .75) with scores on the MMPI Depression scale.³

And Biggs et al. state that “previous investigations and the results of our study indicate that the ZSDS is a valid and sensitive measure of clinical severity in depressed patients and support its continued use as a research instrument.”⁴

The Questionnaire for Pastors

The Questionnaire for Pastors is a four-page, five-section instrument prepared as a two-sheet booklet and developed following the models introduced by Benjamin Schoun; Roy M. Oswald, as presented by Schoun; and Lee and Balswick, as adapted by

¹William W. K. Zung, “From Art to Science: The Diagnosis and Treatment of Depression,” *Archives of General Psychiatry* 29 (1973): 328-227.

²See Knight et al., 245-249; Beckham and Leber, 73-74; L. M. Giambra, “Independent Dimensions of Depression: A Factor Analysis of Three Self-Report Depression Measures,” *Journal of Clinical Psychology* 33 (October 1977): 928-935; and J. T. Biggs, L. T. Wylie, and V. E. Ziegler, “Validity of the Zung Self-Rating Depression Scale,” *British Journal of Psychiatry* 132 (April 1978): 381-385. For the Spanish adaptation and evaluation see Conde, Escriba, and Izquierdo, 281-302.

³Buross, 138.

⁴Biggs, Wylie, and Ziegler, 381.

Valenzuela.¹ The wording of the questions is similar to the instruments they used, although additional questions relevant to the specific topic of this dissertation were developed under the supervision of Drs. Valenzuela, Kijai, and Rodríguez.

The questionnaire was originally prepared in English, and then translated into Spanish. Both the English and Spanish versions of the questionnaire were pretested with three SDA pastors for clarification of meaning and proper wording.

In addition to general demographic information, the survey was intended as an explorative measurement of nine major areas that may contribute to depression in the ministerial profession: (1) marital and family issues; (2) work-related issues; (3) spiritual issues and devotional life; (4) educational background and intellectual development; (5) lifestyle and health; (6) emotional health; (7) social life and support systems; (8) financial issues; and (9) stressful life events.

Following the suggestions of Zikmund,² a mix of different rating scales was used to help keep the respondents focused and to avoid response bias. These included two six-point category scales, a six-point Likert scale, yes/no questions, and open-ended questions. Numerical scales were used in conjunction with semantic ones to facilitate both the responses and the processing of the survey data.

¹These surveys can be found in: Valenzuela, "An Ecosystemic Analysis of Marital Satisfaction in Seventh-day Adventist Clergy Families," 86-87, 166-169; and Schoun, *Helping Pastors Cope*, 204-226; and Miller and Jackson, 460-461.

²William G. Zikmund, *Business Research Methods* (Fort Worth, TX: Dryden, 1997), 351-372.

Research Subjects and Procedure

Research Subjects

Because of the limited number of Hispanic SDA ministers in the North American Division, the questionnaires were sent to all 405 pastors involved in Hispanic work and listed in the local conference directories of the NAD. Of these, two had retired, two no longer worked as ministers, and one responded declining his participation in the survey, so the actual survey population was reduced to 400 ministers, of which 57.3 percent ($N=229$) responded. Seven questionnaires, though, were not valid because they were incomplete, therefore the results are based on the 55.5 percent ($N=222$) complete surveys received.

Several research authors state that Hispanics, although more open to personal interviews, have a very low survey return rate.¹ Yet, in spite of the sensitivity of the issues discussed, 229 ministers (57.3%) mailed the surveys back, suggesting that the topic of the study was of great interest to the chosen population. In addition, several respondents added personal comments or letters sharing some of their personal problems, expressing their interest in the topic, and indicating their hope to see the results of the research.

The respondents are all males, ranging from 23 to 79 years of age, with a mean of 46.5. Tables 2, 3, and 4 show additional information on the age, place of birth, and educational level of the respondents.

Of the ministers who responded, 83.8 percent ($N=186$) work full-time as ministers, and 16.2 percent ($N=36$) work on a part-time basis; 79.7 percent ($N=177$) are ordained. As to previous ministerial experience, table 5 shows that their years of service range from

¹Ibid., 246-251.

Table 2. Age of the Respondents

AGE	<i>N</i>	PERCENTAGE
23-30	19	8.6
31-40	52	23.4
41-50	73	32.9
51-60	49	22.1
61-70	26	11.7
71-79	3	1.3
Total	222	100.0

Table 3. Place of Birth of the Respondents

PLACE	<i>N</i>	PERCENTAGE
Mexico	44	19.8
Interamerica (excluding Mexico)	42	18.9
Caribbean Islands	55	24.8
South America	59	26.6
USA	21	9.4
Other	1	0.5
Total	222	100.0

Table 4. Educational Level of the Respondents

TITLE OBTAINED	<i>N</i>	PERCENTAGE
BA in Theology	57	25.7
MDiv	47	21.2
Other Master Degree	98	44.1
DMin	15	6.8
EdD/PhD	5	2.2
Total	222	100.0

Table 5. Years in Ministry of Respondents

YEARS	<i>N</i>	PERCENTAGE
Under 5	32	14.4
6-10	29	13.1
11-20	73	32.9
21-30	55	24.7
31-40	29	13.1
41 and over	4	1.8
Total	222	100.0

a few months to 60 years, with a mean of 18.5 years in the ministry.

These ministers are currently serving in different churches settings: 70.2 percent ($N=156$) work in urban settings; 22.1 percent ($N=49$) in suburban areas; and 7.7 percent ($N=17$) in rural churches. The number of churches they are in charge of range between 1 and 6—38.7 percent ($N=86$) of the ministers have one church, 34.3 percent ($N=76$) have two churches, 18.9 percent ($N=42$) have 3 churches, 6.3 percent ($N=14$) have 4 churches, 1 pastor has 5, and 3 pastors have 6 churches. As to the length of time they have served in their current church/es, it varies from 1 to 25 years, with a mean of 3 years; 66.7 percent ($N=148$) of the respondents have been there for three years or less, and 45 percent ($N=100$) have served 3 years or less in their previous church or church district.

Data related to the ministers' marital and family life show a mean of 21 years of marriage and 2.2 children per family. Tables 6 and 7 present and expand this data. Additional information on the research population will be given in connection with the description and analysis of the results of both questionnaires.

Research Procedure

Support for this research was secured both at the local Union and Division levels, and the address list of all Hispanic ministers was updated from all local conferences. Two cover letters were prepared for the first mailing, one by Dr. Eradio Alonso, Associate Director of the NAD Ministerial Department, and the other signed by Dr. Alfonso Valenzuela and myself. Both letters specified the purpose of the study, assured the participants of the seriousness and confidential nature of their responses, and encouraged

Table 6. Years of Marriage of Respondents

YEARS	N	PERCENTAGE
0 - Singles	7	3.2
Just married -5	17	7.7
6-10	22	9.9
11-20	62	27.9
21-30	71	32.0
31-40	38	17.1
41 and over	5	2.2
Total	222	100.0

Table 7. Number of Children of the Respondents

# OF CHILDREN	N	PERCENTAGE
0	18	8.1
1	27	12.2
2	88	39.6
3	72	32.4
4	13	5.9
5	1	0.4
6	3	1.4
Total	222	100.0

ministers to participate in the study. The second letter—and all subsequent ones—were personalized with the name of the minister in the salutation. Copies of both letters can be found in appendix A.

Three sets of letters were mailed, spaced three weeks apart, and each one eliminating the names of those who had responded to the previous one/s. Samples of these letters can also be seen in appendix A. The envelopes in which those letters were sent had a special stamp—different each time—from the commemorative series of *Classical American Aircraft*, following Zikmund's advice on methods to increase survey response rate.¹ The envelopes were stamped with "Address Correction Requested" to obtain the proper addresses for subsequent mailings, and each one contained a self-stamped envelope, addressed to Hispanic Ministers Research and a P. O. box in Berrien Center to emphasize the privacy of the research. Ministers living in Canada received a dollar each for stamps, together with the return envelope.

As the responses were returned, all those who had given their names were sent a copy of the SDS questionnaire results, together with a personalized letter thanking them for participating. Those with depressive symptomatology above the normal range were advised to seek professional assistance for a proper diagnosis to determine the need for help to work through the situation. Of the 222 complete responses, 62.2 percent ($N=138$) identified themselves and received this last letter.

¹Ibid.

Analysis and Interpretation of the Results

The Zung Self-rating Depression Scale

The results of this instrument show that a considerable percentage of the respondents present elevated levels of depressive symptomatology—levels above the normal range (50 and over according to table 1)—indicating presence of psychopathology, or different degrees of depression. Table 8 introduces the SDS scores of the respondents, and figure 1 translates these into degrees of depression, based on the scale in table 1.

As figure 1 shows, according to the SDS scores, 23.9 percent ($N=53$) of the respondents appear to have some degree of depression. These results reflect a higher incidence of depression among the population of this research than the results reported by the ECA and NCS studies mentioned in chapters 2 and 3. We need to be careful, though, when comparing studies that deal with different populations and different methods. Nevertheless, these elevations are consistent with several studies placing clergymen among the professionals most vulnerable to depression,¹ and with Polischuk's study of Hispanic Protestant ministers—also mentioned in previous chapters—which reported “statistically significant elevations in scales measuring an ideal image, depression, somatization, non-conformity, aggression, and anxiety . . . in comparison to their Anglo counterparts.”²

Table 9 presents the answers to the twenty different items on the SDS instrument by frequency of responses and percentages of the total population. Even though

¹Previous chapters mention several such studies, among them the ones conducted by Anderson and Haynes.

²Polischuk, 1.

Table 8. SDS Scores of the Respondents

SCORES	CATEGORY	N	PERCENTAGE
25		1	0.5
26		3	1.4
28		4	1.8
29		6	2.7
30		3	1.4
31		5	2.3
33	Within normal range - no psychopathology	9	4.1
34		7	3.2
35		10	4.5
36		9	4.1
38		15	6.8
39		14	6.3
40		12	5.4
41		12	5.4
43		9	4.1
44		9	4.1
45		11	5.0
46		9	4.1
48		14	6.3
49		7	3.2
50		9	4.1
51		3	1.4
53	Minimal to Mild Depression	9	4.1
54		4	1.8
55		4	1.8
56		8	3.6
58		2	0.9
59		5	2.3
61	Moderate to Marked Depression	3	1.4
63		1	0.5
64		1	0.5
68		2	0.9
70	Severe to Extreme	1	0.5
76	Depression	1	0.5
Total		222	100.0

Fig. 1. Level of depression of respondents according to SDS scores, with the percentage they represent of the total population, and the actual number of ministers within each category.

Table 9. SDS Itemized Description of Answers
(Percentages of Total Population and *N* Given
in Parenthesis)

STATEMENT	NONE OR A LITTLE OF THE TIME	SOME OF THE TIME	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
1. I feel down-hearted and blue.	50.0 (111)	42.8 (95)	6.3 (14)	0.9 (2)
2. Morning is when I feel the best.	36.5 (81)	36.0 (80)	15.8 (35)	11.7 (26)
3. I have crying spells or feel like it.	79.7 (177)	19.4 (43)	0.5 (1)	0.5 (1)
4. I have trouble sleeping at night.	55.4 (123)	31.5 (70)	9.0 (20)	4.1 (9)
5. I eat as much as I used to.	32.4 (72)	14.0 (31)	28.8 (64)	24.8 (55)
6. I enjoy looking at, talking to, and being with attractive women/men.	19.8 (44)	18.0 (40)	28.8 (60)	33.3 (74)
7. I notice that I am losing weight.	80.6 (179)	14.9 (33)	3.2 (7)	1.4 (3)
8. I have trouble with constipation.	75.7 (168)	20.3 (45)	3.6 (8)	0.5 (1)
9. My heart beats faster than usual.	78.4 (174)	19.4 (43)	1.8 (4)	0.5 (1)
10. I get tired for no reason.	59.9 (133)	32.0 (71)	7.2 (16)	0.9 (2)
11. My mind is as clear as it used to be.	35.1 (78)	27.0 (60)	27.5 (61)	10.4 (23)
12. I find it easy to do the things I used to.	26.6 (59)	33.8 (75)	32.9 (73)	6.8 (15)
13. I am restless and can't keep still.	52.3 (116)	31.5 (70)	12.2 (27)	4.1 (9)
14. I feel hopeful about the future.	3.6 (8)	7.2 (16)	17.6 (39)	71.6 (159)
15. I am more irritable than usual.	41.0 (91)	47.3 (105)	9.0 (20)	2.7 (6)
16. I find it easy to make decisions.	31.1 (69)	38.3 (85)	27.9 (62)	2.7 (6)
17. I feel that I am useful and needed.	2.7 (9)	11.7 (26)	41.0 (91)	43.2 (96)
18. My life is pretty full.	2.3 (5)	12.2 (27)	41.9 (93)	43.7 (97)
19. I feel that others would be better off if I were dead.	92.8 (206)	5.9 (13)	0.9 (2)	0.5 (1)
20. I still enjoy the things I used to.	45.0 (100)	29.3 (65)	19.8 (44)	5.9 (13)

76.1 percent ($N=169$) of the respondents did not present elevated depressive symptomatology on the SDS test, looking at the answers more carefully it can be noticed that at least some of the time 50 percent ($N=111$) of the respondents feel down-hearted and blue (Item 1), 46.6 percent ($N=99$) have trouble sleeping (Item 4), and 59 percent ($N=131$) are more irritable than usual (Item 15).

Also, there appears to be among the respondents some diminished clarity of mind (Item 11), diminished capacity to make decisions (Item 16), and diminished ability to do the things they used to (Item 12). Some of these answers may be connected to factors other than depression, such as age—the mean age of the respondents is 46.5 years—or temporary situations. But these and other answers could also reflect problems of stress and burnout, which were referred to in chapter 3.

For instance, although there appears to be a tremendous wealth of experience among Hispanic SDA ministers—with a mean of 18.5 years in the ministry—the answers to the SDS instrument show that only 43.2 percent ($N=96$) feel useful and needed (Item 17) and 43.7 percent ($N=97$) think their lives are pretty full (Item 18) most of the time. Furthermore, only 45 percent ($N=100$) enjoy the things they used to (Item 20).

Finally, 7.3 percent ($N=16$) of the respondents at least some of the time think that others would be better off if they (the respondents) were dead. When these answers are compared to those given to the question *Have you ever attempted suicide?*, included on the Questionnaire for Pastors—to which 8 respondents answered positively (2 of them explaining their attempts had happened when they were either very young or had not met Jesus yet)—it seems justifiable to conclude that, indeed, depression is a current and

important problem among the chosen population and that further awareness, study, and disclosure of the matter could prove crucial and highly beneficial.

Methods Used to Relate the Results of the SDS Scores to Those of the Questionnaire for Pastors

Two methods were used in relating results of the two survey/questionnaires used in this research. First, percentile norms were used to make comparisons between the results of both surveys and to pinpoint relevant findings or discrepancies. Second, the *Statistical Program for Social Studies* (SPSS) computer program applied two different Pearson's correlation formulas—chi-square and Spearman—to test the correlation between the SDS scores on the one hand, and the demographic data and the responses to the Questionnaire for Pastors on the other hand. The results of these tests can be found in the appendix C (tables 36-42), but only correlation coefficients that were at least at a 0.05 level of significance ($p = 0.05$) or 95% confidence level are reported here.

Correlations Between SDS Scores and Demographic Data

Chi-square tests were conducted between the SDS scores and the place of birth, educational level, employment basis, ordination status, and church settings of the respondents. The results of these analyses show there is no statistically significant correlation between elevated levels of depressive symptomatology on the SDS test and any of these demographic data. See these results in appendix C (tables 36 to 40).

Even so, the employment basis (full-time versus part-time) data present a considerably higher proportion of elevated depressive symptomatology on the SDS test

among the part-time pastors than the full-time pastors. This may be due to the difficulties of accomplishing the ministerial tasks on a part-time basis or because doing so may increase the minister's sense of frustration, that "pervading sense of incompleteness that keeps the body's systems in a state of alertness and makes full relaxation impossible,"¹ which chapter 3 mentioned. Furthermore, the economic struggles and the need to have a second job to survive financially add pressure to these ministers. Of the 36 part-time ministers who answered the survey, 10 listed problems related to their part-time status as the most difficult thing about being in the ministry (Question 66 in the Questionnaire for Pastors): having to do other jobs to subsist, financial problems resulting from the part-time situation, and working full-time but being paid part-time.

Spearman correlation tests related the SDS scores to the age of the respondents, years in the ministry, number of churches they serve, years at current church, years at last church, years of marriage, and number of children. Table 41 in appendix C presents this data and, again, no statistically significant correlation was found between the demographic data tested and elevated levels of depressive symptomatology on the SDS test.

The results of these correlations are consistent with the literature presented in previous chapters which refers to depression as 'the common cold'² of mental-health problems not respecting age, sex, occupation, education, or ethnic background, even though certain groups within the population may be more susceptible than others.

¹Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 20, 21.

²See Quinn, 4; Collins, 105.

The Questionnaire for Pastors

As previously stated, this questionnaire is intended as an explorative measurement of major areas that may be related to depression in the ministerial profession. The nine areas selected (marital and family issues; work-related issues; spiritual issues and devotional life; educational background and intellectual development; lifestyle and health; emotional health; social life and support systems; financial issues; and stressful life events) were derived from the literature reviewed in previous chapters. In this section, the questionnaire answers connected to each of these areas are presented in percentile norms, and statistically significant Spearman's correlations between them and elevated levels of depressive symptomatology on the SDS survey are given and analyzed. (See table 42 in appendix C for a complete list of all statistically significant Spearman correlations.)

Marital and Family Issues

As presented in chapter 3, marital and family problems are among the most common psychological/cognitive causes of depression. In the case of the minister, marital and family problems are even more difficult to handle because of the intimate relationship between work and family roles in the ministry. Because of this, fourteen items in the Questionnaire for Pastors—specified in tables 10 through 13—are directly related to marital or family dynamics. They deal with issues such as time spent together as a couple and as a family, couple communication, mutual trust and respect, sexual life, general marriage satisfaction, and wife and family's support of and/or stress resulting from the ministry. In addition to these, questions listed in other areas are also associated with

Table 10. Marital and Family Issues (Questions 4, 7, 8)
(Percentages of Total Population and *N* Given
in Parenthesis)

EVALUATE WHETHER YOU HAVE . . .	SCALE					
	1	2	3	4	5	6
4. Quality time spent with my spouse	1.8 (4)	21.2 (47)	59.5 (132)	9.9 (22)	3.6 (8)	4.0 (9)
7. Quality time spent with my children and/or extended family	2.7 (6)	39.7 (88)	43.7 (97)	4.5 (10)	4.0 (9)	5.4 (12)
8. Intimacy / Sexual life	4.5 (10)	20.7 (46)	63.1 (140)	5.9 (13)	1.8 (4)	4.0 (9)

Note: 1 = Far too little; 2 = Too little; 3 = Just right; 4 = Too much; 5 = Far too much; 6 = Doesn't apply.

Table 11. Marital and Family Issues (Questions 13, 18, 20, 21)
(Percentages of Total Population and *N* Given in Parenthesis)

HOW SATISFIED ARE YOU WITH THE FOLLOWING ASPECTS OF YOUR LIFE?	SCALE					
	1	2	3	4	5	6
13. Communication with my spouse	8.6 (19)	26.1 (58)	46.4 (103)	13.1 (29)	1.8 (4)	4.0 (9)
18. My spouse's trust and respect for me	19.8 (44)	33.3 (74)	32.5 (72)	6.8 (15)	3.6 (8)	4.0 (9)
20. How I treat my spouse	10.4 (23)	26.2 (58)	44.1 (98)	13.5 (30)	1.8 (4)	4.0 (9)
21. My spouse working outside the home	1.8 (4)	8.1 (18)	36.5 (81)	10.3 (23)	2.3 (5)	41.0 (91)

Note: 1 = Very happy; 2 = Happy; 3 = Just right; 4 = Unhappy; 5 = Very unhappy; 6 = Doesn't apply.

Table 12. Marital and Family Issues (Questions 24, 27, 30, 33, 36)
(Percentages of Total Population and *N* Given in Parenthesis)

HOW STRONGLY DO YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS?	SCALE					
	1	2	3	4	5	6
24. My wife is happy working outside the home.	8.1 (18)	33.8 (75)	3.6 (8)	12.6 (28)	4.0 (9)	37.9 (84)
27. The ministry creates much stress for my family.	11.7 (26)	38.2 (85)	5.9 (13)	32.9 (73)	7.7 (17)	3.6 (8)
30. I am contented with my marriage.	53.6 (119)	34.7 (77)	2.3 (5)	4.0 (9)	1.8 (4)	3.6 (8)
33. My wife feels she is fulfilling the congregation's expectations.	19.3 (43)	51.8 (115)	12.2 (27)	10.4 (23)	2.3 (5)	4.0 (9)
36. My wife supports my ministry.	57.2 (127)	31.1 (69)	1.8 (4)	5.4 (12)	0.5 (1)	4.0 (9)

Note: 1 = Strongly agree; 2 = Agree; 3 = Don't know; 4 = Disagree; 5 = Strongly disagree; 6 = Doesn't apply.

Table 13. Marital and Family Issues (Questions 50, 51)
(Percentages of Total Population and *N* Given
in Parenthesis)

ANSWER THE FOLLOWING QUESTIONS AS HONESTLY AS POSSIBLE	YES	NO	DOESN'T APPLY
50. Do you share with your wife the education and discipline of your children?	79.7 (177)	2.3 (5)	18.0 (40)
51. Do you generally take your weekly day off to rest and be with your family?	56.3 (125)	43.7 (97)	—

marital and family issues, such as question 22 dealing with the overall spirituality of the pastor's family, questions dealing with emotional health, social support sources, stressful life events, and the open-ended questions at the end of the questionnaire.

Seventy-six percent of the respondents ($N=162$) consider they spend enough quality time with their spouses (Question 4); but this appears contradicted by the fact that 43.7 percent ($N=97$) do not take their weekly day off to be with the family (Q 51). And even though 44.7 percent of the respondents ($N=94$) believe they do not spend enough quality time with their children and/or extended family (Q 7), 97.3 percent ($N=111$) of them say they share with their wives the education and discipline of their children (Q 50).

Nearly 74 percent of the respondents ($N=157$) believe that they have enough intimacy in their marriage (Q 8), while 84.5 percent ($N=180$) are satisfied with the level of communication with their spouses (Q 13); 89.2 percent ($N=190$) are satisfied with their spouses' trust and respect for them (Q 18), and a slightly lower 84 percent ($N=179$) are satisfied with the way they treat their spouses (Q 20). Overall, 93.9 percent of married ministers ($N=201$) agree they are contented with their marriages (Q 30).

Fifty-nine percent ($N=131$) of the ministers' wives work outside the home; 67.4 percent of these women—according to their husbands' opinions—are satisfied with this situation (Q 24), and 78.6 percent of the ministers are also satisfied with it (Q 21). On the other hand, 92 percent ($N=196$) of married ministers agree that their wives support their ministry (Q 36), but only 74.2 percent ($N=158$) think their wives feel they are fulfilling the congregation's expectations, and more than half—52 percent of respondents ($N=111$)—agree that ministry creates much stress for their family (Q 27).

There appears to be ambivalence in the way the respondents perceive their relationship with their wives and families. While on the one hand they gave high ratings to marriage satisfaction and most other relationship issues, almost half of them acknowledged that they do not take the weekly day off to be with their families, and ratings are lower in all questions—listed here and in the lifestyle section—dealing with time spent together, resting, and in social or recreational activities. It is evident that there are conflicts of interest and some confusion on how to balance time at home and at work. The most frequent answer to the open-ended question on the most difficult thing about being in the ministry for the minister's family (Q 66) was lack of time to be together, with 48 ministers giving that or similar answers. On the other hand, several respondents answered open-ended question 67 on the single greatest advantage of being a minister with expressions such as “to serve God 24 hours a day,” “to use all our time to serve the Lord and advance His cause,” and “to burn ourselves up in the service of our friend Jesus Christ.” Although there is nothing explicitly wrong with these expressions, they may imply a one-sided vision of what God expects of His ministers and a distorted belief that because we are serving the Lord 24 hours a day, it becomes somehow acceptable to neglect the family and the self.

Statistically significant correlations were found between elevated depressive symptomatology on the SDS survey and the stress that ministry creates for the pastors' families (-.185), the way ministers treat their wives (.167), the ministers' sharing in the education of their children (.212), and their contentment with their marriage (.267). These correlations are significant and show that these variables are related to elevated levels of depression. See the list of Spearman correlations in appendix C.

Work-Related Issues

The ten questions directly related to this area—presented on tables 14-16—deal with the ministers' relationship with their superiors, the congregation's appreciation of their work, the way the congregation's problems affect them personally, respondents' satisfaction with their work, and the frequency of their moves. Additional questions related to work issues were listed in the previous area—wives and families' support of and/or stress resulting from the ministry—or are presented further on, including weekly number of hours worked (Q 45) and other lifestyle issues, respondents' opinions on probable causes of past and/or present depression (Q 60 and 62), and stressful life events.

Almost 80 percent of respondents ($N=176$) are satisfied with their relationship with their superiors (Q 11) and 76.1 percent ($N=169$) agree that their superiors are pleased with their work (Q 23). Yet, 21.6 percent ($N=48$) do not know whether their superiors are pleased or not. This may reflect some lack of communication or feedback from the superiors to support and affirm the work of these ministers. Eighty-two percent ($N=182$) of the respondents are comfortable with the expectations the SDA Church has of them (Q 48), and nearly 96 percent of them ($N=213$) believe they made the right decision in entering the ministry (Q 47), even though 19.8 percent ($N=44$) are unhappy with the congregation's appreciation of their work (Q 15), 43.7 percent ($N=97$) believe there is a sense of competition among the pastors in their conferences (Q 40), and 59.9 percent ($N=133$) agree that the problems and conflicts in the church/es affect them personally (Q 35). And although 20.7 percent ($N=46$) have seriously considered leaving the ministry (Q28), 87 percent ($N=194$) are happy working as pastors (Q 32). Of the 222 respondents,

Table 14. Work-Related Issues (Questions 11, 15)
(Percentages of Total Population and *N* Given
in Parenthesis)

HOW SATISFIED ARE YOU WITH THE FOLLOWING ASPECTS OF YOUR LIFE?	SCALE					
	1	2	3	4	5	6
11. My relationship with my superiors	5.0 (11)	17.1 (38)	57.2 (127)	16.2 (36)	4.5 (10)	—
15. The congregation's appreciation of my work	7.2 (16)	22.1 (49)	50.9 (113)	16.2 (36)	3.6 (8)	—

Note: 1 = Very happy; 2 = Happy; 3 = Just right; 4 = Unhappy; 5 = Very unhappy; 6 = Doesn't apply.

Table 15. Work-Related Issues (Questions 23, 28, 32, 35, 40)
(Percentages of Total Population and *N* Given in Parenthesis)

HOW STRONGLY DO YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS?	SCALE					
	1	2	3	4	5	6
23. My superiors are pleased with my work.	29.3 (65)	46.8 (104)	21.6 (48)	2.3 (5)	—	—
28. I have seriously considered leaving the ministry.	4.5 (10)	16.2 (36)	4.1 (9)	25.7 (57)	49.5 (110)	—
32. I am happy in my ministry.	48.2 (107)	39.2 (87)	5.8 (13)	5.4 (12)	1.4 (3)	—
35. The problems and conflicts in my church/es affect me personally.	1.2 (27)	47.7 (106)	5.8 (13)	25.7 (57)	8.6 (19)	—
40. There is a sense of competition among the pastors in my conference.	16.7 (37)	27.0 (60)	24.3 (54)	23.0 (51)	9.0 (20)	—

Note: 1 = Strongly agree; 2 = Agree; 3 = Don't know; 4 = Disagree; 5 = Strongly disagree; 6 = Doesn't apply.

Table 16. Work-Related Issues (Questions 47, 48, 52)
(Percentages of Total Population and *N* Given
in Parenthesis)

ANSWER THE FOLLOWING QUESTIONS AS HONESTLY AS POSSIBLE	YES	NO	DOESN'T APPLY
47. Do you think you made the right decision in entering the ministry?	95.9 (213)	4.1 (9)	---
48. Are you comfortable with the expectations the SDA Church has of you?	82.0 (182)	17.5 (39)	0.5 (1)
52. In the last 10 years, have you moved more than 2 times?	79.3 (176)	20.7 (46)	---

79.3 percent ($N=176$) have moved more than twice in the last 10 years (Q 52).

Work-related issues have been correlated to high levels of stress and burnout in many studies—several of which were mentioned in previous chapters. This research shows that there are also statistically significant relationships between them and elevated levels of depressive symptomatology. Of the ten items in this section, eight were significantly correlated: the respondents' relationship with their superiors (.212), the congregation's appreciation of their work (.224), superiors pleased with their work (.310), seriously considered leaving the ministry (-.166), happiness in the ministry (.184), problems and conflicts in church/es affect them personally (-.143), sense of competition among pastors (-.162), and comfortable with the expectations of SDA Church (.208). Again, these correlations are significant and show that, indeed, there is a relationship between work-related issues and depression. See the complete list of Spearman correlations in appendix C.

Finally, two open-ended questions (Q 66 and 67) gave ministers the opportunity to share their opinions on what is the most difficult thing about being in the ministry for the minister and his/her family, and what is the single greatest advantage of being in the ministry for the pastor. Tables 17 and 18 list the different answers given, grouped together by similarity of wording, and organized in decreasing order by the number of responses. Most of them reflect issues that have been referred to in this study, and overall they show not only the struggles pastors have to find balance in their lives but also the deep satisfaction and joy they experience in serving God.

Table 17. Family/Work-Related Issues (Question 66)
Organized by Similarity of Wording and
Number of Responses

ANSWER THE FOLLOWING QUESTIONS AS HONESTLY AS POSSIBLE	N
66. For our family, the most difficult thing about being in the ministry is:	
* Lack of time to be together/schedules do not agree/balance between time for church and family	48
* Frequent moves/change of children's schools and work for wives	25
* Congregations' demands/expectations of the minister and his/her family ..	24
* Lack of understanding and criticism from the congregations (specially when directed to children)	20
* Leaders/conference/colleagues' lack of consideration, politics, unfair demands or unethical behavior	14
* Financial limitations and problems/wife having to work outside to make ends meet	12
* Lack of privacy/public life of minister and family/being the center of attention/glass house/fear of bad witness	10
* Work stress and long hours	10
* Live up to the expectations of perfection on the minister	7
* Conflicts of time, interests, and priorities (too many "hats" to wear)	7
* Dealing with conflicts, arguments and problems between church members	6
* Lack of Adventist schools for children/children away to study/traveling long distances for children's Adventist education	5
* Too many churches to serve/too much traveling involved	4
* Loneliness	3
* Lack of time to fulfill the ministry's requirements	3
* Not being able to live near children	2
* Trying to please everybody	1
* Lack of conference support to build church schools	1
* Sadness of working with people who reject God	1
* Adaptation to life in the US	1
* Dealing with boards	1
* Visitors constantly coming to our home	1
* Adolescent son	1
* Getting ready for church with two small kids	1
* Immigration status	1

Note: These answers do not include the ones already referred to in relation to part-time employment status.

Table 18. Work-Related Issues (Question 67)
Organized by Similarity of Wording and
Number of Responses

ANSWER THE FOLLOWING QUESTIONS AS HONESTLY AS POSSIBLE	N
67. What is the single greatest advantage of your being in the ministry?	
* The privilege/joy of serving God/His church/fellowmen by preaching the Gospel	90
* The joy of seeing people transformed/coming to Christ/baptized	62
* Being closer to the Lord/daily dependence on Him	10
* The privilege of working for others and bringing them closer to God	9
* Knowing I am the Lord's anointed/God's representative on earth/ an instrument in His hands	8
* Doing what I love/following my call/using my talents and gifts	8
* Receiving God's blessings and care	4
* People's appreciation of my ministry/people's expressions of love	4
* To see my children and wife involved in church activities	4
* Seeing the spiritual growth of the members/building the church	4
* Satisfaction of doing God's will	3
* To know that God is using me in spite of my limitations	3
* That my children are in the church	3
* Working with the young people at church	1
* Flexible hours	1
* Being heard and respected	1
* Meet brethren and sisters I worked with in the past who continue to be faithful to the Lord	1

Spiritual Issues and Devotional Life

As spiritual leaders, ministers face the daily challenge of living what they preach. And it is only through intimacy with the Source of spiritual life, spiritual growth, and divine power that they may succeed in this endeavor. Cultivating this personal relationship with God should be, therefore, a high priority in the ministers' lives. Unfortunately, our many activities sometimes leave us with little time for this, the most important of all our responsibilities.

No one becomes a "minister." Rather in trust we so open ourselves to the Spirit that Jesus Christ can express his ministry through us. Prayer and ministry, therefore, are indissoluble. In the stillness of meditative prayer we are confronted by God's loving claim upon us—the most intense intimacy a human being can experience.¹

But not only for ministers is spiritual and devotional life paramount. As we saw in chapter 3, sin, guilt, self-condemnation, and hopelessness are among the causes of depression—although by no means the only ones—and every person needs to experience God's forgiveness and peace in order to become a whole human being and experience spiritual as well as emotional and mental health. The questionnaire included three questions on this area, which are presented in tables 19 and 20.

Between one fifth and one third of the respondents acknowledged their need to devote more time in their spiritual growth: 22.5 percent of the respondents ($N=50$) thought they spend too little time in prayer and meditation (Q 9), 33.3 percent ($N=74$) expressed they are unhappy with the time they spend nourishing their spiritual life (Q 16), and 23 percent ($N=51$) said the same about the overall spirituality of their family (Q 22).

¹Fenhagen, 9.

Table 19. Spiritual Issues and Devotional Life (Question 9)
(Percentages of Total Population and *N* Given
in Parenthesis)

EVALUATE WHETHER YOU HAVE . . .	SCALE					
	1	2	3	4	5	6
9. Prayer and meditation	0.5 (1)	22.0 (49)	64.0 (142)	11.7 (26)	1.8 (4)	—

Note: 1 = Far too little; 2 = Too little; 3 = Just right; 4 = Too much; 5 = Far too much; 6 = Doesn't apply.

Table 20. Spiritual Issues and Devotional Life (Questions 16, 22)
(Percentages of Total Population and *N* Given in Parenthesis)

HOW SATISFIED ARE YOU WITH THE FOLLOWING ASPECTS OF YOUR LIFE?	SCALE					
	1	2	3	4	5	6
16. The time I devote to nourishing my own spiritual life	1.8 (4)	18.5 (41)	46.4 (103)	29.7 (66)	3.6 (8)	—
22. The overall spirituality of our family	4.5 (10)	17.5 (39)	52.7 (117)	20.7 (46)	2.3 (5)	2.3 (5)

Note: 1 = Very happy; 2 = Happy; 3 = Just right; 4 = Unhappy; 5 = Very unhappy; 6 = Doesn't apply.

Yet, no statistically significant correlations were found between any of these variables and elevated depressive symptomatology on the SDS test.

Although the limited size of the survey population and the small number of questions related to this area prevent us from reaching conclusions because that could distort the reality, these data appear to confirm what has been emphasized before, that even though “spiritual” reasons may be among the causes of depression, they are not the only ones. Indeed, in this survey population there appears to be no statistically significant relationship between elevated depressive symptomatology on the SDS test and the ministers’ spiritual and/or devotional lives.

Furthermore, although probably all of us would benefit from a closer relationship with God and a stronger devotional life, the danger also exists of setting impossibly high expectations of ourselves and/or becoming judgmental and self-condemnatory, feeling we never achieve our goals or are not “good enough.” Indeed, this thought pattern could contribute to depressive symptomatology.

Educational Background and Intellectual Development

Three questions dealt with issues related to opportunities and achievements in the area of professional growth. Tables 21 and 22 show that 17.5 percent ($N=39$) of the respondents thought they have too little or far too little professional growth (Q 2), 22.1 percent ($N=49$) expressed they are unhappy with the opportunities for educational growth provided by the conference (Q 12), and 23.4 percent ($N=52$) shared their displeasure with the level of education they have achieved (Q 19).

Table 21. Educational Background and Intellectual Development (Question 2)
(Percentages of Total Population and *N* Given in Parenthesis)

EVALUATE WHETHER YOU HAVE . . .	SCALE					
	1	2	3	4	5	6
2. Professional growth	1.3 (3)	16.2 (36)	65.8 (146)	14.0 (31)	2.7 (6)	---

Note: 1 = Far too little; 2 = Too little; 3 = Just right; 4 = Too much; 5 = Far too much; 6 = Doesn't apply.

Table 22. Educational Background and Intellectual Development (Questions 12, 19)
(Percentages of Total Population and *N* Given in Parenthesis)

HOW SATISFIED ARE YOU WITH THE FOLLOWING ASPECTS OF YOUR LIFE?	SCALE					
	1	2	3	4	5	6
12. The opportunities for educational growth provided by my conference	4.0 (9)	17.6 (39)	55.8 (124)	14.0 (31)	8.1 (18)	0.5 (1)
19. The level of education I was able to achieve	11.7 (26)	17.6 (39)	47.3 (105)	19.4 (43)	4.0 (9)	---

Note: 1 = Very happy; 2 = Happy; 3 = Just right; 4 = Unhappy; 5 = Very unhappy; 6 = Doesn't apply.

Although again we must be careful as to how we interpret these results, all three variables in this area show statistically significant correlations with elevated levels of depressive symptomatology on the SDS test. Their values are as follows: professional growth (-.174), opportunities for educational growth provided by the conference (.186), and level of education the minister was able to achieve (.130). In fact, this is the only area in which all variables are significantly correlated with elevated levels of depressive symptomatology on the SDS test. It seems clear that a number of respondents feel quite strongly about their need for professional growth.

Lifestyle and Health

Chapter 3 mentioned that depression often has a physical basis. Therefore, lifestyle and other physical health issues are critical to this study. Several of them were included in the Questionnaire for Pastor. Tables 23-26 present the eleven questions directly related to this section.

More than half of the respondents—56.7 percent ($N=126$)—believe they do too little or far too little physical exercise (Q 1), 85.1 percent ($N=189$) work more than 45 hours per week (Q 45), 56.3 percent ($N=125$) do not go to the doctor for a regular check-up (Q 53), and 43.7 percent ($N=97$) do not take their weekly day off to rest and be with their families (Q 51). Furthermore, 19.4 percent ($N=43$) believe they do not eat a balanced diet (Q 26), and almost 33 percent ($N=73$) sleep less than 7 hours per night (Q 49). In addition, 9.9 percent ($N=22$) have someone in their close family seriously ill, which adds additional stress to them (Q 55).

Table 23. Lifestyle and Health (Questions 1, 5)
(Percentages of Total Population and *N*
Given in Parenthesis)

EVALUATE WHETHER YOU HAVE . . .	SCALE					
	1	2	3	4	5	6
1. The amount of physical exercise that I get	12.6 (28)	44.1 (98)	38.3 (85)	3.6 (8)	1.4 (3)	—
5. Vacation and leave time	6.3 (14)	36.5 (81)	50.9 (113)	3.6 (8)	2.7 (6)	—

Note: 1= Far too little; 2 = Too little; 3 = Just right; 4 = Too much; 5 = Far too much; 6 = Doesn't apply.

Table 24. Lifestyle and Health (Question 10)
(Percentages of Total Population and *N*
Given in Parenthesis)

HOW SATISFIED ARE YOU WITH THE FOLLOWING ASPECTS OF YOUR LIFE?	SCALE					
	1	2	3	4	5	6
10. The time I spend in recreation and enjoyable activities	3.2 (7)	8.1 (18)	50.0 (111)	29.7 (66)	9.0 (20)	---

Note: 1 = Very happy; 2 = Happy; 3 = Just right; 4 = Unhappy; 5 = Very unhappy; 6 = Doesn't apply.

Table 25. Lifestyle and Health (Questions 26, 38, 44)
(Percentages of Total Population and *N* Given
in Parenthesis)

HOW STRONGLY DO YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS?	SCALE					
	1	2	3	4	5	6
26. I eat a balanced diet.	19.8 (44)	55.4 (123)	5.4 (12)	15.8 (35)	3.6 (8)	—
38. I need to learn to manage my time better.	21.2 (47)	57.2 (127)	3.2 (7)	14.4 (32)	4.0 (9)	—
44. I believe that some extra time off, like a sabbatical would help me pull myself together.	32.4 (72)	37.4 (83)	13.5 (30)	12.2 (27)	4.5 (10)	—

Note: 1 = Strongly agree; 2 = Agree; 3 = Don't know; 4 = Disagree; 5 = Strongly disagree; 6 = Doesn't apply.

Table 26. Life Style and Health (Questions 45, 49, 51, 53, 55)
(Percentages of Total Population and *N* Given in Parenthesis)

ANSWER THE FOLLOWING QUESTIONS AS HONESTLY AS POSSIBLE	YES	NO	DOESN'T APPLY
45. Do you normally work more than 45 hours per week?	85.1 (189)	14.9 (33)	---
49. Do you sleep a minimum of 7 hours per night?	67.1 (149)	32.9 (73)	---
51. Do you generally take your weekly day off to rest and be with your family?	56.3 (125)	43.7 (97)	---
53. Do you go to the doctor for a regular check-up?	43.7 (97)	56.3 (125)	---
55. Is somebody in your close family (spouse, children) seriously ill?	9.9 (22)	89.2 (198)	0.9 (2)

Regarding time management, almost 80 percent ($N=174$) agreed that they need to learn to manage their time better (Q 38), and in regard to vacations, time for recreation, and sabbaticals, 42.8 percent ($N=95$) believe they have too little vacation and leave time (Q 5), 38.7 percent ($N=86$) are unhappy with the time they spend in recreation and enjoyable activities (Q 10), and 69.8 percent ($N=155$) believe they could benefit greatly from some extra time off, like a sabbatical (Q 44). The answers to this last question indicate that a high percentage of respondents feel that the pressures of the ministerial task could be relieved and lightened with some additional time off to distance themselves from the everyday pastoral routine to renew strengths and regain perspectives.

Of these variables, five show statistically significant correlations with elevated levels of depressive symptomatology on the SDS test: time spent in recreation and enjoyable activities (.138), balanced diet (.231), need to manage time better (-.131), sleeping a minimum of 7 hours per night (.148), and taking the weekly day off (.231).

The answers to this section give evidence once again of imbalance in the use of time, and some neglect in the care of self. The choice of giving all of ourselves to the Lord should not result in becoming stressed, burnout, or sick. On the contrary, as we surrender ourselves to God, we are challenged to obey His two greatest commandments, the second of which tells us to love our neighbors as ourselves (or vice versa, ourselves as our neighbors!). Proper management of our time and priorities and taking good care of our bodies and minds are essential to that end. If not, we may not have a self to surrender!

Emotional Health

Table 27 presents the eight questions tackling issues connected with the emotional health and related history of the respondents. Although 26.1 percent ($N=58$) of the respondents said they had close relatives suffering from depression (Q 56), this did not prove to be statistically significant with elevated levels of depression on the SDS test. On the other hand, 12.2 percent ($N=27$) of the respondents admitted they become discouraged rather easily (Q 57) and this did prove statistically significant ($-.309$), emphasizing the close relationship between thought patterns and physical health in general and depression in particular. Only two of the eight people who attempted suicide in the past (Q 58) show current elevated levels of depressive symptomatology on the SDS test, and both of them also acknowledged suicidal thoughts on the SDS questionnaire (Q 19). One of these ministers provided his name and was strongly advised to seek professional help to work out his situation. Unfortunately, the other one sent his questionnaires anonymously and could not be contacted.

Almost 30 percent ($N=62$) of the respondents believe they are currently experiencing some degree of depression (Q 59). There is a statistically significant correlation ($-.381$) between their perceptions and the actual elevated levels of depressive symptomatology as found on the SDS tests. In fact, 31 of the 53 respondents with elevated levels of depressive symptomatology on the SDS test were aware of or suspected their problem. This is positive in the sense that being aware of a problem is the first step to solving it. On the other hand, 22 respondents were not aware of it or were in denial, even though a few of them showed moderate to severe levels of depressive

Table 27. Emotional Health (Questions 56-63)
(Percentages of Total Population and *N*
Given in Parenthesis)

ANSWER THE FOLLOWING QUESTIONS AS HONESTLY AS POSSIBLE	YES	NO	DOESN'T APPLY
56. Does a close relative of yours suffer from depression?	26.1 (58)	73.4 (163)	0.5 (1)
57. Do you become discouraged rather easily?	12.2 (27)	87.8 (195)	---
58. Have you ever attempted suicide?	3.6 (8)	96.4 (214)	---
59. Do you think you are experiencing some degree of depression right now?	27.9 (62)	72.1 (160)	---
60. If yes, can you pinpoint the main reason/s?*			
Family issues	45.2 (28)		
Health problems	21.0 (13)		
Work-related issues	51.6 (32)		
Financial problems	56.5 (35)		
Other/Please explain	12.9 (8)		
61. Have you experienced depression in the past?	40.1 (109)	50.9 (113)	---
62. If yes, can you pinpoint the main reason/s?**			
Family issues	33.9 (37)		
Health problems	16.5 (18)		
Work-related issues	66.1 (72)		
Financial problems	37.6 (41)		
Other/Please explain	14.7 (16)		
63. What helped you to overcome your depression in the past? (Check as many as may apply)**			
Medical treatment	12.8 (14)		
Better health habits	22.0 (24)		
The support of the family	56.9 (62)		
Counseling	28.4 (31)		
The support of your friends	29.4 (32)		
A stronger devotional life	66.1 (72)		
Taking care of unsolved issues of the past	28.4 (31)		
Other/Please explain	13.8 (5)		

*These percentages are based on the 62 respondents who answered "Yes" to question 59.

**These percentages are based on the 109 respondents who answered "Yes" to question 61.

symptomatology on the SDS test. As to the other 31 ministers, the ones who thought they were experiencing depression but did not score above the normal range on the SDS test, they could be confusing symptoms of stress or burnout with depression. Undoubtedly, they would also benefit from learning about the coping mechanisms, preventive measures, and curative alternatives presented in chapter 5.

Among the reasons perceived by the respondents as the causes of their current depressive symptomatology (Q 60), financial problems, work-related problems, and family issues were the three most frequently cited ones. Most of the respondents listed two or more different reasons. Some of the “other” reasons given included: social issues—loneliness, unmarried status—personality problems, language difficulties, immigration situation, and problems of morality.

Just over 49 percent ($N=109$) of the respondents answered that they had experienced depression in the past (Q 61). Although there is no way of knowing how many of them actually experienced depression in the medical sense, it appears to be a very high number. Even more striking is the fact that 37 of those currently experiencing elevated levels of depressive symptomatology, according to the SDS test, answered they had experienced depression in the past, revealing an apparent repetitive pattern which is particularly worrisome. When sharing perceptions on causes for past depression (Q 62), by far the most frequent reason given was work-related problems followed by financial and family issues. Other reasons given were immigration problems, pressures of studies, personality, broken relationships, loss of loved ones, and spiritual and morality issues.

Finally, the respondents listed what they believed had helped them overcome their

perceived depression in the past. Again, most respondents selected two or more options; a stronger devotional life and the support of family were the two most frequent ones, followed very closely by the support of friends, counseling, and taking care of unsolved issues of the past. In addition to better health habits and medical treatment, other things listed included: change of working place, support of the conference, additional sources of income/wife's job, finished studies, setting achievable goals, and more involvement in social and sport activities. Some of these answers suggest their problems could have been other than depression in the medical sense, such as stress, burnout, unresolved guilt problems, or any number of other things. Even so, their problems were not less serious or real and therefore finding ways to prevent or cope with them in the future could make a significant difference in the lives of all those involved.

On the other hand, the fact that 66.1 percent ($N=72$) of those who said they had experienced depression in the past, considered that a stronger devotional life had been the main way to overcome depression, reflects a tendency to "spiritualize" the problem, somehow minimizing the physical and psychological implications of depression. Only 28.4 percent ($N=31$) resorted to counseling and 12.8 percent ($N=14$) to medical treatment. This could imply a misunderstanding of depression as an illness and some bias on the options of treatment considered. These biases in ministers are especially worrisome since they can be transmitted directly or indirectly to church members suffering from similar problems and could also prevent them from receiving proper and timely treatment.

Social Life and Support Systems

In spite of the underlying barriers ministers experience in developing social support networks, most clergy do have some type of support. What supports are working best for them? Clearly, what is effective for one person may not be the best option for another. Individuals choose different kinds of people for support depending on the nature of the issue and the kind of support needed. A vast majority will turn to their spouses for support, and although this is good, it may not be enough. Furthermore, what happens when the source of stress or crisis is the marriage itself?

Tables 28-31 present the answers to the twelve questions dealing directly with social life and support systems. Of the total survey population, 26.6 percent ($N=59$) think they have too little friendship (Q 3), 12.2 percent ($N=27$) are unhappy with the social support from friends and family (Q 17), and 39.2 percent ($N=87$) agree they often feel lonely. Almost seventy percent ($N=150$) of the respondents would be reluctant to share their problems with others for fear that private issues may become public (Q 25), 19.8 percent ($N=44$) would not see a professional counselor even if needed (and an additional 12.2 percent— $N=27$ —are not sure) (Q 29), and when dealing with sensitive personal problems only 39.2 percent ($N=87$) would feel confident to go to their conference administration for support (Q 34) and 51.8 percent ($N=115$) have fellow pastors with whom they would share them (Q 39). Almost 45 percent ($N=99$) fear their reputation and job might be at stake if they share their problems with others (with an additional 14.4% — $N=32$ —respondents who do not know) (Q 41), 39.6 percent ($N=88$) have no one to go to when they feel discouraged and lonely (Q 42), and an astonishing 31.1 percent ($N=69$)

Table 28. Social Life and Support Systems (Question 3)
(Percentages of Total Population and *N* Given
in Parenthesis)

EVALUATE WHETHER YOU HAVE . . .	SCALE					
	1	2	3	4	5	6
3. Friendship	3.6 (8)	23.0 (51)	53.6 (119)	12.6 (28)	7.2 (16)	—

Note: 1 = Far too little; 2 = Too little; 3 = Just right; 4 = Too much; 5 = Far too much; 6 = Doesn't apply.

Table 29. Social Life and Support Systems (Question 17)
(Percentages of Total Population and *N* Given
in Parenthesis)

HOW SATISFIED ARE YOU WITH THE FOLLOWING ASPECTS OF YOUR LIFE?	SCALE					
	1	2	3	4	5	6
17. The social support from friends and family	6.7 (15)	21.2 (47)	59.9 (133)	9.0 (20)	3.2 (7)	—

Note: 1 = Very happy; 2 = Happy; 3 = Just right; 4 = Unhappy; 5 = Very unhappy; 6 = Doesn't apply.

Table 30. Social Life and Support Systems (Questions 25, 29, 31, 34, 37, 39, 41-43)
(Percentages of Total Population and *N* Given in Parenthesis)

HOW STRONGLY DO YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS?	SCALE					
	1	2	3	4	5	6
25. I would be reluctant to share my problems with others for fear that private issues may become public.	28.8 (64)	38.7 (86)	3.2 (7)	22.1 (49)	7.2 (16)	---
29. I would see a professional counselor if I needed one.	26.1 (58)	41.9 (93)	12.2 (27)	12.6 (28)	7.2 (16)	---
31. I often feel lonely.	9.5 (21)	29.7 (66)	4.5 (10)	37.8 (84)	18.5 (41)	---
34. I feel confident to go to my conference administration for support in sensitive personal problems.	12.6 (28)	26.6 (59)	12.2 (27)	31.5 (70)	17.1 (38)	---
37. I believe I should seek advice only from God when I am going through personal problems.	11.7 (26)	19.4 (43)	7.7 (17)	45.0 (100)	16.2 (36)	---
39. I have fellow pastors with whom I feel free to share sensitive personal problems.	8.1 (18)	43.7 (97)	6.8 (15)	28.3 (63)	13.1 (29)	---
41. I fear my reputation and job might be at stake if I share my problems with others.	13.5 (30)	31.1 (69)	14.4 (32)	27.9 (62)	13.1 (29)	---
42. I have no one to go to when I feel discouraged and lonely.	11.7 (26)	27.9 (62)	5.0 (119)	40.5 (90)	14.4 (32)	0.5 (1)
43. More opportunities to work and fellowship with fellow pastors would benefit my ministry.	35.1 (78)	47.7 (106)	11.7 (26)	5.0 (11)	0.5 (1)	---

Note: 1 = Strongly agree; 2 = Agree; 3 = Don't know; 4 = Disagree; 5 = Strongly disagree; 6 = Doesn't apply.

Table 31. Social Life and Support Systems (Question 65)
 (Percentages of Total Population and *N* Given
 in Parenthesis)

ANSWER THE FOLLOWING QUESTIONS AS HONESTLY AS POSSIBLE		% AND <i>N</i>
65. If you felt discouraged, and you needed to seek counsel, whom would you see (mark all that may apply)?		
Your spouse		76.1 (169)
Other family member/s		24.8 (55)
A fellow minister		42.9 (102)
A professional counselor		44.1 (98)
A close friend/not a church member from your congregation.		2.3 (5)
A close friend/a church member from your congregation.		19.4 (43)
The conference president		11.3 (25)
The ministerial secretary		21.2 (47)
Other/Explain		19.4 (43)

believe they should seek advice only from God when they are going through personal problems (Q 37). Overall, this section provided the saddest picture about the struggles of these pastors. Several pastors added personal heartbreaking comments such as, “I have no one to talk to,” “In this line of work you can’t trust anyone with your problems,” and a pastor who presented a severe to extreme level of depressive symptomatology wrote, “I have no one to go to, I don’t trust anybody and I don’t want to worry my wife.”

Statistically significant correlations were found between elevated levels of depressive symptomatology on the SDS test and the amount of friendship (-.183), reluctance to share problems with others (-.221), confidence to go to the conference administration for support with personal problems (.133), the believe that advice should be sought only from God (-.209), fear for reputation and job if sharing problems (-.229), and the lack of someone to go to when discouraged (-.273). Agreement with question 31 (often feeling lonely) presented the highest correlation in the study (-.393) at a 100 percent confidence level ($p=0.00$). Answers to question 65—presented in table 31—present a list of people ministers would be willing to seek for advice and encouragement. Among the “others” listed, several added God—which the survey questionnaire took for granted— and a few others included a retired pastor, a former pastor friend of mine, and the conference or union Hispanic coordinator. An apparent discrepancy was found between the 68 percent ($N=151$) who said they would see a professional counselor if needed, in question 29, and the lower 44.1 percent ($N=98$) who said they would seek counsel from a professional counselor if discouraged, in question 65. This could be caused by the different phrasing of the two questions, but it could also

reflect some ambiguity in their willingness to search out professional counseling.

It is possible that cultural issues, immigration problems—recent arrival, lack of friends and family, or extended family in this country, language barriers—negative past experiences, and even misconceptions of some of Ellen G. White’s quotations on this topic/s—some of which are reviewed in chapter 5—may have played a role in the development of these attitudes. Yet, it is apparent that a great number of pastors would like to see things working differently: 82.8 percent ($N=184$) agreed that more opportunities to work and fellowship with fellow pastors would benefit their ministry (Q 43), and these and other measures could also provide social support networking opportunities which appear to be one of the most urgent needs of this survey population.

Financial Issues

Tables 32-34 introduce the four questions dealing with financial issues. Of these respondents, 31.5 percent ($N=70$) believe that they have too little financial resources (Q 6), and 27 percent ($N=60$) are unhappy with their salary (Q 14); 57.7 percent ($N=128$) have debts of over \$10,000 (excluding home mortgages) (Q 46), and 33.3 percent ($N=74$) have debts of less than \$10,000 (excluding home mortgages) (Q 54). This makes a total of 91 percent ($N=202$) who are apparently spending more than what they earn, even though 59 percent of ministers’ wives work outside their homes—as seen in the family section. Statistically significant correlation was found between elevated levels of depressive symptomatology and the lack of satisfaction with the salary (.135).

Table 32. Financial Issues (Question 6)
(Percentages of Total Population and
N Given in Parenthesis)

EVALUATE WHETHER YOU HAVE . . .	SCALE					
	1	2	3	4	5	6
6. Financial Resources	7.6 (17)	23.9 (53)	64.4 (143)	2.7 (6)	1.4 (3)	—

Note: 1 = Far too little; 2 = Too little; 3 = Just right; 4 = Too much; 5 = Far too much; 6 = Doesn't apply.

Table 33. Financial Issues (Question 14)
(Percentages of Total Population and N
Given in Parenthesis)

HOW SATISFIED ARE YOU WITH THE FOLLOWING ASPECTS OF YOUR LIFE?	SCALE					
	1	2	3	4	5	6
14. My salary	2.7 (6)	10.8 (24)	59.5 (132)	19.8 (44)	7.2 (16)	—

Note: 1 = Very happy; 2 = Happy; 3 = Just right; 4 = Unhappy; 5 = Very unhappy; 6 = Doesn't apply.

Table 34. Financial Issues (Questions 46, 54)
(Percentages of Total Population and *N*
Given in Parenthesis)

ANSWER THE FOLLOWING QUESTIONS AS HONESTLY AS POSSIBLE	YES	NO	DOESN'T APPLY
46. Do you have debts for a total of over \$10,000.00? (Excluding home mortgage)	57.7 (128)	42.3 (94)	---
54. Do you have debts for a total of less than \$10,000.00? (Excluding home mortgage)	33.3 (74)	66.7 (148)	---

As chapter 3 emphasizes, probably no pastor entered the ministry in order to make money, but the weight of their financial struggles and/or debts may be heavy and may lead ministers to higher levels of stress, preventing them from carrying out a more effective ministry. Furthermore, frequent moves may prevent their wives from getting better paying, stable jobs. Dr. Valenzuela's study of SDA ministers found this as "the number one reason Adventist ministers would consider leaving the ministry," "and not having enough money was the major area of family stress."¹

Stressful Life Events

Thomas Holmes and Richard Rahe listed forty-three life events which have been found to be particularly stressful.² Their basic premise, proven correct in four separate research efforts, is that the greater the number of social adjustments individuals make, the greater their potential for physical illness. An adaptation of their stress scale, prepared specifically for pastors, was proposed by Roy Oswald of the Alban Institute.³ Seven of the eight top events listed in this scale were included in this section of the Questionnaire for Pastors.

Because this is a partial list, the results of this section cannot be used to measure levels of stress in the participants, but the results—presented in table 35—show that

¹Valenzuela, "An Ecosystemic Analysis of Marital Satisfaction in Seventh-day Adventist Clergy Families," 58.

²T. H. Homes and R. H. Rahe, "The Social Readjustment Rating Scale," *Journal of Psychosomatic Research* 11 (April 1967): 213-218.

³Oswald, 29-35.

Table 35. Major Crisis (Question 64)
(Percentages of Total Population and
N Given in Parenthesis)

ANSWER THE FOLLOWING QUESTIONS AS HONESTLY AS POSSIBLE		% AND <i>N</i>
64. Have you experienced any of the following over the last 12 months?		
Death of spouse		---
Divorce/marital separation		1.4 (3)
Death of a close family member		14.0 (31)
Serious injury or illness of a close family member		23.9 (53)
Marriage		4.5 (10)
Geographical relocation		32.4 (72)
Personal injury or illness.		7.7 (17)

stressful life events were quite proportionately spread over the total population: 75 respondents listed one stressful event during the last year—29.3 percent ($N=22$) of whom showed elevated levels of depressive symptomatology on the SDS test, and of the 47 ministers reporting two or more stressful events during the last year, 25.5 percent ($N=12$) belong to this group. When these percentages are compared with the 23.9 percent ($N=53$) of respondents who are suffering from different degrees of depressive symptomatology according to the SDS survey results, we see that the incidence of major crisis in this group is only slightly greater than for those presenting no psychopathology. We can only speculate here that this would appear to indicate that major crises were not a determining factor in most of the respondents who experienced depressive symptomatology.

Conclusion

The analysis of the two instruments mailed to the Hispanic SDA ministers shows that a considerable percentage of the survey population presents elevated levels of depressive symptomatology according to the results of the SDS survey. It also shows that there appears to be no statistically significant correlation between these elevated levels and the demographic data of the respondents. See tables 36-41 in Appendix C.

On the other hand, by exploring nine major areas that may contribute to depression in the ministerial profession, the research was able to establish statistically significant correlations, with most of these areas demonstrating once again the complexity of this illness which is usually related to a combination of many factors. The survey respondents showed ambivalence in their perceptions of their couple/family relationships,

revealing struggles to find balance between time at home and at work, and even neglect of the family and the self, which may be due in part to a somewhat distorted vision of what God expects from His ministers. Nonetheless, the survey answers also reflected the commitment of these ministers to their pastoral call, and the joy and fulfillment they experience by serving God and guiding people to Him.

Areas of improvement were made especially evident in the respondents' strong desire for further educational and professional growth, their expressed need to learn and practice better time management principles, and their even more urgent need to develop social support systems that may provide them with networking, friendship, and counseling opportunities. Chapter 5 develops these topics further, and introduces suggestions on preventive, coping, and curative measures that may be useful to all ministers.

CHAPTER V

RECOMMENDATIONS AND CONCLUSIONS

Christians have been given excellent resources for preventing and coping with both physical and emotional illnesses, even though these measures do not exempt them completely from experiencing illnesses and pain. This chapter presents preventive measures, coping mechanisms, and curative alternatives for dealing with depression. Most of these recommendations are directed to the ministers, but some suggestions for the minister's family, church members, seminaries, and/or the conferences that employ them are also included.

Preventive Measures

A healthy and balanced lifestyle—involving the spiritual, mental, physical, and social aspects of life—is the most effective antidepressant. Not only is this critical in preventing depressions but it also provides the best healing alternatives.¹ Here are some recommendations on how to achieve that balance in life.

¹Hulme and Hulme, 77.

Personal Resources

Learn to Take Proper Care of Your Body

As we have seen, depression is tied to our physiology as much as it is to our psychology. Ministers, like all other people, are subject to natural laws. Depression caused by fatigue, stress, poor diet, or other abuses of the body can be avoided or controlled.

1. *Eat a proper diet*: “Many of our ministers are digging their graves with their teeth”¹ was Ellen G. White’s strong warning. She also advised us:

Strict temperance habits, combined with exercise of the muscles as well as of the mind, will preserve both mental and physical health, and give power of endurance to those engaged in the ministry, to editors, and to all others whose habits are sedentary. . . . Indulgence of appetite is the greatest cause of physical and mental debility, and lies at the foundation of the feebleness which is apparent everywhere.²

2. *Increase your physical activity*: 56.7 percent ($N=126$) of the survey respondents expressed they did too little physical exercise.

The minister who seldom or never engages in physical exercise is inviting the onset of depression. The work of ministry is sedentary in nature. It therefore takes deliberate planning and determined effort to make physical exercise a part of the daily routine. But studies have shown conclusively that the lack of adequate physical conditioning can have many disastrous consequences—both physical and psychological. In fact, a recent development in the treatment of severe depression is the use of vigorous exercise. The precise curative mechanism is not clearly understood, but the improvement in mood following adequate exercise is quite impressive.³

In Jesus’ days life had a slower pace. Jesus did not drive or fly to his destinations.

¹White, *Testimonies for the Church*, 4:408.

²Ellen G. White, *Counsels on Health* (Mountain View, CA: Pacific Press, 1951), 123.

³Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 16.

The telephone, fax, and mail services were not there. Walking provided Jesus with the benefits of a healthy body and mind stimulated by what He saw around Him. “What Jesus did out of necessity, we need to make time to do intentionally. Walking, stopping to look at the creation around us can deliver great benefits to our body and mind.”¹

3. *Rest and take time out:* The answers to the survey showed this as another area that needs urgent attention. With 32.9 percent ($N=73$) of the respondents sleeping less than 7 hours per night, 43.7 percent ($N=97$) not taking the weekly day off to rest, and 85.1 percent ($N=189$) working more than 45 hours a week, there is much room for improvement here.

Too many Adventist ministers preach against addiction while they themselves are being addicted—to work! If you are proud of overwork, you may well have both an ego problem and a theological problem. Get your sleep each night. Take your day off each week. Take your vacation each year. Jesus would. Although He had only three and a half years to get His work done, He made sure His disciples got their rest. On several occasions He took them aside for the purpose of resting.²

Rest time is not wasted! We need time off on a daily, weekly, monthly, and yearly basis. In the long run, it is far more efficient to rest and gather fresh strength, ideas, and perspectives before going back to the work field.

4. *Learn relaxation techniques and use them regularly:* As the body relaxes, the heart rate and breathing become slower, blood pressure decreases, brain waves shift from an alert beta rhythm to a relaxed alpha rhythm, and blood flow to the brain and skin

¹Peter R. Brain, “Care and Support for the Pastor in Ministry, with Special Emphasis on the Pastor’s Self-care” (D.Min. dissertation, Fuller Theological Seminary, 1994), 67.

²Ministerial Association, General Conference of Seventh-day Adventists, *Seventh-day Adventist Minister’s Handbook* (Silver Spring, MD: General Conference, 1997), 36.

increases, producing a feeling of warmth and quiet mental alertness. Relaxation techniques are an excellent way of counteracting the debilitating effects of chronic stress.¹

5. *See your doctor regularly:* Between the ages of 18 and 30, people are advised to have a complete physical check-up at least every 6 years; from 31 to 40 every 3 years; between 41 and 60 every 2 years; and people 65 and over should have annual check-ups.² Your family doctor will decide if and when additional visits may be required based on specific needs. Cultivate a relationship with the doctor and obey his or her counsel.³

The NAD insurance company—Risk Management—will cover these periodical exams and they should be taken seriously. Unfortunately, 56.3 percent ($N=125$) of the survey respondents are not doing this now, and with a mean age of 46.5, ministers in this survey population really cannot afford to be so careless about this matter.

Introduce Changes in Your Attitudes and Actions

1. *Watch your thought patterns:* Avoid catastrophic thinking, overgeneralizing, and mislabeling. Clear and rational thinking helps avoid unnecessary depression. This idea is biblical: Prov 23:7 reminds us that “as he thinks in his heart, so is he,” and Paul advises us, “your attitude should be the same as that of Christ Jesus” (Phil 2:5). Later he encourages us to think about things that are true, honest, just, pure, lovely, and of good

¹Insel et al., 28.

²Adventist Risk Management, *Health Care Assistance Plan* (Silver Spring, MD: Adventist Risk Management, 1998), 46.

³James L. Johnson, “The Ministry Can Be Hazardous to Your Health,” *Leadership* 1 (Winter 1980): 38.

report (Phil 4:8). Why? Because if we think about these things, we will become like them.

2. *Include laughter and fun in your life:* Laughter is probably the ultimate stress reliever, a built-in tranquilizer, and healer. You can actually alter your mood if you smile, because a smile or a laugh produces changes in the autonomic nervous system. Laughter lowers heart rate and blood pressure, aids digestion, and eases pain by releasing endorphins.¹

Theologian Reinhold Niebuhr wrote, “Humor is a prelude to faith, and laughter is the beginning of prayer.”² Make some time for a funny movie or story, or a good joke.

When people become depressed, they often feel that it is wrong to have fun. Maybe they don’t believe they could enjoy themselves. Maybe they “can’t afford the time” to have fun. . . . When they took fun out of life, their entire world became problem oriented. To kick depression they must open their world again to laughter and enjoyment.³

“A cheerful heart is good medicine, but a crushed spirit dries up the bones,” said wise King Solomon (Prov 17:22). Ellen G. White expanded on this, “A contented mind, a cheerful spirit, is health to the body and strength to the soul. Nothing is so fruitful a cause of disease as depression, gloominess and sadness.”⁴

3. *Find pleasure in other activities:* There is danger in becoming so narrowly focused on our ministry that we find fulfillment only through our work. Almost 40

¹Insel et al., 31.

²Tom Neven, “Lessons from the Hart,” *Focus on the Family*, April 1999, 2.

³Everett L. Worthington, *How to Help the Hurting* (Downers Grove, IL: Inter Varsity, 1985), 103-104.

⁴White, *Testimonies for the Church*, 1:702.

percent ($N=86$) of survey respondents expressed their unhappiness with the time they spend in recreational and enjoyable activities. We would benefit greatly from spending more time involved in hobbies (gardening, walking, collecting stamps, woodworking, fishing, etc.), sports, arts (museums, art galleries, concerts, etc.), and reflective or expressive work (journal keeping, poetry writing, singing, instrument performing, etc.).

Furthermore, we must plan our time wisely to make sure that it provides the relaxation and enjoyment expected of it.

The most popular American escape is television. Given all the alternatives, it is a poor route to detachment. It may get our minds off certain subjects for a time, but it is rarely either relaxing or satisfying TV drains us emotionally without giving us a sense of self-worth or a capacity to cope with life. Once the off button is pushed, we feel as empty as the screen.¹

Maybe a way around this could be to place a stationary bicycle in front of the television set and make a rule that the news or any other favored TV program can be watched only if the exerciser is being used!²

Spiritual Resources

1. *Take time to be alone with God*: Christ often separated Himself from the people and found a place and a time to be alone with His Father. "Christian ministry and the quest for solitude are indissoluble companions."³ Solitude provides the context for that inner relationship with God where ministry has its roots.

¹Oswald, 188.

²Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 92.

³Fenhagen, 59.

2. *Read the Bible and pray*: “Devoting some time each day to our spiritual health, especially to prayer and Bible meditation, is an antidepressant.”¹ Ellen G. White advised us that “we . . . must have times set apart for meditation and prayer and for receiving spiritual refreshing. We do not value the power and efficacy of prayer as we should. Prayer and faith will do what no power on earth can accomplish.”²

3. *Praise God and express your gratitude*: Praise is the secret weapon God has given every child of His with which to defeat the enemy. Praising can renew the passion and recapture the fire of our relationship with God. “God dwells where His name is praised. So if you’re feeling lately that He has packed up and gone fishing, I suggest you take a praise break.”³ Singing, reading psalms, keeping a “blessings journal” are just a few ways of doing this. Bible verses that can help us here are 1 Thess 5:18; Rom 8:28; Eph 5:20; Phil 4:4; Isa 61:3; and Pss 103; 119:164.

4. *Trust in God*: The apostle Paul wrote from prison that he had learned to be content in all circumstances (Phil 4: 11). A conviction that God is alive and in control can give hope, even when we are tempted to be discouraged and without hope.⁴

Miller and Jackson summarized the importance of these and other spiritual resources in these words:

¹Hulme and Hulme, 78.

²White, *Ministry of Healing*, 509.

³Randy Maxwell, “5 Ways to Restore Your Spiritual Passion,” *Signs of the Times*, April 1999, 13.

⁴Collins, 115.

Our experience is that pastors, in time of personal need, are pastors in need of personal time. . . . It is often precisely when one ‘has the least time’ that time spent in spiritual disciplines is most urgent. The time-honored disciplines of prayer, solitude, meditation, fasting, study, and simplicity—it is for good reason that these have survived for so many centuries. They are spiritual sustenance and survival skills. At the center of pastoring is *theos logos*—the word, the knowledge of God.¹

Family Resources

Just as marital problems are among the most common precipitators of depression, marital satisfaction and family unity can provide strong factors of emotional stability. In order to enhance marital and family togetherness, Dr. Roger L. Dudley suggests the following essential things:²

1. *Be faithful and loyal to each other*: This is the starting place and the basic foundation over which the marriage and the family can be solidly built.

2. *Share marital intimacy*: King Solomon gave us a beautiful picture of this in Prov 5:18-20. Dr. Dudley advises us that “husband and wife are to be closer to each other than to anything else in the world. Pastor, that relationship is to take precedence over your career, over your studies, over your hobbies, over the conference goals, over your side interests, over everything.”³

3. *Devote sufficient quality time to each other*: It should be dependable high-quality time—time your spouse and children can count on—time to work together, to play together, and to do fun things together; time away from your ministerial duties!

¹Miller and Jackson, 466.

²Roger L. Dudley, “The Minister as a Husband,” in *The Adventist Minister*, 27.

³Ibid., 32.

The *SDA Minister's Handbook* shares an anecdote of Martin Luther hanging out diapers and the neighbors laughing at him. Luther then exclaimed, "Let them laugh. God and the angels smile in heaven."¹ After God, this is our first priority and, accordingly, significant quality time should be blocked out for your wife and children. And no one should feel or be made to feel guilty about doing it!

4. *Communicate deeply with your wife and children:* Share your feelings, your hopes, and your concerns. Be willing to listen, and learn how to do it lovingly, nonjudgmentally, and actively. Express your feelings; we never outgrow the need to be touched and hugged.

5. *Respect and affirm each other and the kids:* Express your love for each other in words and actions, raise each other's self-esteem by being outspoken about what qualities you value in each other. See how you can compliment and support each other.

6. *Make family worship a priority:* Family worship should be a daily and happy experience, and pastors should make time to participate in it. "Nothing can excuse the minister for neglecting the inner circle for the larger circle outside. The spiritual welfare of his family comes first."² Furthermore, couples could spend time praying together for each other, their common interests, and concerns. This would be a special growing experience.

Although there are unique stresses in the pastoral family, there are also special advantages. David and Vera Mace present a list of advantages of clergy marriage extracted

¹*SDA Minister's Handbook*, 49.

²Ellen G. White, *Gospel Workers* (Washington, DC: Review and Herald, 1915), 204.

from surveys of ministers and their wives.¹ The list includes “being called of God to serve him in a special capacity,” “being part of a loving fellowship of believers,” “the opportunity to work as a team on tasks of eternal significance,” “a strong sense of purpose and mission in life,” “satisfaction of helping people in the very best way they can be helped—finding God’s love,” and “working in a people oriented vocation that really has the answers.”

Maintaining a happy and supportive pastor’s marriage and family, even though challenging, is well worth the effort.

Educational and Professional Resources

Just as physical fitness requires regular exercise, continuing education provides fitness for the mind. Pastors should diligently and prayerfully search for ways to improve their work, and administrators should explore and provide ways in which the capabilities of the pastor can be increased and the fruitfulness of the ministers multiplied.²

What Can the Minister Do?

1. *Set aside time for study:* In addition to reading the Bible, ministers should set aside time for daily study. Plan on it and enter it into your daily schedule. Ellen G. White’s books or other Christian books, sermon tapes, or videos, or any other educational tool may provide excellent material for new ideas, new insights, and growth.

2. *Attend seminars:* Magazines and brochures in the mail offer all kind of seminars

¹Mace and Mace, 118-119.

²Orley Berg, *The Work of the Pastor* (Nashville, TN: Southern Publishing, 1966), 13.

on religious or secular topics. Make plans to attend one a year or every other year on topics that interest you or that you feel you would benefit from, such as conflict resolution, time or money management, investment strategies, marriage enrichment, couple communication, computer proficiency, or any number of other topics. Do not wait for others to regulate your areas of growth, be proactive about it.

3. *Take advantage of opportunities:* Take advantage of all opportunities offered to you by the conference or the seminary for continuous education, enrichment, and growth.

4. *Involve your spouse in personal growth opportunities:* Help your spouse feel a part of your ministry and this will motivate her/him in her/his personal growth.

What Can Seminaries Do?

Seminaries provide educational resources to ministers in many ways. Some of these resources are provided during the ministerial training years; others are or could be offered later on. A few suggestions to those planning the ministerial curriculum.

1. *Address and encourage the “whole person” in ministry:* In addition to the academic preparation in theology, seminaries could provide guidance on spiritual formation, personal growth, and physical and social well-being.

2. *Counteract the cultural ideal of self-sufficiency:* Search for excellence in ministry involves the creative development of one’s gifts. Help the ministers to discover their own strengths and weaknesses, and help them realize the human aspects of their ministry with its limitations and challenges.

3. *Provide special training:* Additional seminar-type classes on behavioral and

human relationship skills (conflict resolution, difficult personalities, and communication problems), and management issues (time and finance management, authority, and delegation) could prove very useful. The seminaries should also take seriously the training of couples to handle the inevitable marital stresses related with ministry.

4. *Offer an internship year before graduation or a “residency” after graduation:*

This would give seminary students the opportunity to work alongside experienced pastors who can function as their mentors.

5. *Keep in contact with alumni:* Seminaries could offer continuing education—summer seminars or enrichment short-term classes—or provide alternatives during crisis periods in the process of the career development.

What Can Conferences Do?

Most conferences are making a conscientious effort to make available as many educational resources as possible to their ministers. Appendix D presents data provided by different conferences on the types of resources they offer to their pastors.

1. *Provide annual opportunities for continuous education:* “The purpose of continuing education is to enable ministers to engage faithfully in authentic ministry and to do so with effectiveness and satisfaction.”¹ Faithfulness in ministry requires growth in competence, and continuing education aims at encouraging this by helping ministers keep in touch with what is going on in the world, and enlarging their knowledge of their faith and the skills required for effective ministry.

¹Mark Rouch, “Getting Smart about Continuing Education,” in *Growth in Ministry*, ed. Thomas E. Kadel (Philadelphia: Fortress Press, 1980), 124.

2. *Equip ministers with the necessary tools:* Make available free of charge or at accessible prices books, magazines, tapes, videos, software, and/or other tools that can enrich the ministers' service, and can also be used in training the laypeople.

3. *Offer mentoring program:* These are "colleagues or peers who offer guidance and support as a pastor to the pastor, or in some specialty significant to pastoring."¹ It is especially valuable for pastors who are just entering the ministry, since these mentors function as guides and role models providing advice and insight based on their experience.

4. *Grant sabbaticals:* "The sabbatical is a biblical concept which in its essence implies rest. It is used in the academic and corporate communities. . . . It is not just continuing education, nor is it a vacation. It is an extended period of renewal, usually three to six months or even up to a year."² Sabbaticals may be used for further study, travel, personal research, writing an article or a book, and reflect on specific concerns.

However a minister spends his/her sabbatical, it is clearly a respite from the taxing routine of preaching, counseling, administration and the other functions that, after several years, constitute a sort of treadmill. . . . The sabbatical is a unique opportunity to recover enthusiasm, perspective and overview, to find again the point in a vocation that has everything to do with meaning and direction in life. It is a wise investment by the church, not only because of what it does for its minister's skills and spirit, but also because of the possibilities it opens up for increased lay involvement and growth in shared leadership.³

Dr. Schoun suggests as a goal a three-to-six-month period of a paid sabbatical after

¹G. Lloyd Rediger, *Clergy Killers* (Louisville, KY: Westminster John Knox, 1997), 156.

²Schoun, *Helping Pastors Cope*, 172-173.

³David C. Pohl, "Ministerial Sabbaticals," *Christian Ministry*, January 1978, 8-9.

five to seven years of service.¹ Of the survey respondents, 69.8 percent ($N=155$) agreed that some extra time off, like a sabbatical, could be very beneficial to their ministry.

Social and Support Resources

“Social resources are supportive social ties that benefit an individual’s psychological well-being by fulfilling needs for affiliation, belonging, guidance, nurturance, and self-esteem.”² The faster pace of our current life, immigration which many times has separated us from our extended families (especially relevant to this survey population), the disintegration of many nuclear families, and other reasons have turned this into an even more critical issue in our day. The survey answers showed that 39.2 percent ($N=87$) of the respondents often feel lonely, and 39.6 percent ($N=88$) have no one to go to when they feel discouraged and lonely.

God is and should be our main source of support. He promised to be always there for us, right to the end of times (Matt 28:20; Heb 8:1-2; 4:15-16; John 14:16-18), and His help is certain even when human help fails. But it is important to understand that this is not the only method God uses in helping us.³ In 2 Cor 7:5-6 Paul wrote, “For when we came into Macedonia, this body of ours had no rest, but we were harassed at every turn—conflict on the outside, fears within. But God, who comforts the downcast, comforted us by the

¹Schoun, *Helping Pastors Cope*, 173.

²Ruth C. Cronkite and Rudolf H. Moos, “Life Context, Coping Processes, and Depression,” in *Handbook of Depression*, ed. E. Edward Beckham and William Leber (New York, NY: Guilford, 1995), 569-587.

³Schoun, *Helping Pastors Cope*, 83-85.

coming of Titus.” God used a friend, a colleague, to provide support and encouragement to Paul. The *SDA Minister’s Handbook* states:

you will need some special help from other people at times. This may come from your spouse, a fellow pastor, a friend, or a support group. Some conferences/missions have a plan to pay anonymously at least part of the fee for counseling with a professional counselor. Don’t be too embarrassed or proud to accept counsel. Plan your life around the expectation that ‘we all need help sometimes.’¹

Every minister needs close confidants to help him with his professional and personal conflicts. If steps are not deliberately taken to develop these trusting and supportive relationships, the loneliness of ministry will lead to isolation, professional ineffectiveness, and a distortion of reasoning, which may lead to depression for many ministers.²

The Bible has many references to the importance of supporting each other, bearing each other’s burdens (Gal 6:2); confessing each other’s sins and praying for one another (Jas 5:16); rejoicing and weeping with one another (Rom 12:15); considering and caring for each other’s things (Phil 2:4); comforting and edifying one another (1 Thess 5:11); comforting the feebleminded, supporting the weak, and being patient toward all men (1 Thess 5:14). As ministers, we are not exempt or beyond any of this wise advice.

Among the different sources of social support, the most frequently referred to include the following.

Family and Friends

A lot has been said already about the importance of the family, but here we need to

¹*SDA Minister’s Handbook*, 37.

²Roy M. Oswald, *How to Build a Support System for Your Ministry* (Washington, DC: Alban Institute, 1991).

add that “the best known and most ubiquitous support system in all societies is the marital and family group.”¹ Obviously, “spouse support” is only as good as the marriage relationship itself, but even if the relationship is excellent, there is a real danger in relying on marital support as the *only* source of support; this can become a very heavy burden.²

Extended family—grown children, siblings, parents, in-laws—and friends can provide additional sources of support. The *SDA Minister’s Handbook* advises us in this regard: “Should pastors have intimate friends? Absolutely. Close, trustworthy, bare-your-soul friendships are not only permissible, but a sign of relational competence and emotional maturity.”³ And it goes on to explain that everybody needs close friends, even Jesus did.

A common complaint among pastors is that there is no time to develop friendship. Ministers should not settle for this. Long-time friendships dating back to college or seminary years, and close friendships with one or two nearby clergy couples are extremely important. Therefore, take the initiative in scheduling social engagements. Plan and make time for special events with extended family or friends at least once or twice a week.

Colleagues

Ellen G. White warns us that “we are too indifferent in regard to one another. Too often we forget that our fellow laborers are in need of strength and cheer. Take care to assure them of your interest and sympathy. Help them by your prayers, and let them know

¹Gerald Caplan, *Support Systems and Community Mental Health* (New York, NY: Behavioral Publications, 1974), 8.

²Gilbert, 51-52.

³*SDA Minister’s Handbook*, 28-29.

that you do it.”¹

Richard Baxter, who served somewhat as a minister to ministers in the 1600s, recommended strongly that ministers not neglect communion among themselves. “Ministers need mutual edification,” he said.² Ministers must have “ventilating relationships” with persons in whom they can trust.

Even the most self-sufficient may be the most deficient, often being the proudest and most empty of men. Therefore some . . . come among the brethren, claiming that they desire to live privately. To these we say, Why do you not on the same grounds forbear going to church? Is not ministerial communion a duty as well as common Christian communion?³

The answers to the survey imply that perceived competitiveness among ministers may be one of the obstacles to making better use of this resource. Others may be unwilling to share vulnerabilities with colleagues, and lack of time or trust. Yet, 82.8 percent ($N=184$) of the respondents would welcome more opportunities to work and fellowship with fellow ministers.

Conference Leaders and Services

Central to a good clergy support group is leadership. But as one minister expressed it, “for us to trust the deeper issues of our lives to leadership, we need to know that it is competent to handle difficult issues, sensitive enough to empathize with each dilemma, and

¹White, *Ministry of Healing*, 492-493.

²Richard Baxter, quoted in Schoun, *Helping Pastors Cope*, 56.

³Richard Baxter, *The Reformed Pastor*, ed. Jay Green (Marshallton, DE: National Foundation for Christian Education, n.d.), 63.

safe so as not to threaten our career in the church.”¹ Conferences can function as network facilitators—providing opportunities for their pastors to intermingle—and as providers of guidance, affirmation, and resources. They can also make available to pastors the services of key support people or groups.

1. *Pastors' pastor*: The reluctance of ministers to seek help from authority figures could be overcome by requesting experienced ministers (even retired ministers), recognized by their sensitivity and high level of confidentiality, to serve as the pastors' pastor.

When pastors try to function as their own pastors, or even as pastors to family and friends, they experience professional limitations similar to those that affect physicians, lawyers, and other human service professionals. Pastors typically have other roles—spouse, parent, friend—that preempt the pastoral role.²

A former pastor expressed his feelings in the following words:

The ministry is the loneliest job in the world, and with rare exception I found fellow pastors too absorbed in their own affairs to be concerned with their fellows. . . . So much could be done to give comfort, aid, and understanding to a fellow pastor. The denominations should have a pastor unrelated to promotional schemes, who would be available as a spiritual troubleshooter. He would be, not an answer man, but one who could come in and hear out the local pastor, absorb his problems, and offer a sympathetic and understanding ear.³

Especially, ministration in crisis and grief is very difficult to administer to oneself, since much of it derives from an outsider's caring and ministering to the need. Spiritual kinship among spiritual leaders is a nurturing experience, and every pastor needs a pastor! Although the ministerial director or Hispanic coordinators—in the specific case of this

¹Roy M. Oswald, “The Vulnerability of Clergy,” *Action Information*, November-December 1981, 7.

²Rediger, 152.

³Jud, Mills, and Burch, 15.

survey population—play an important role here, many pastors feel threatened by their administrative roles. Access to someone completely disconnected with the denominational structure could provide a better environment for openness and trust.¹

2. *Ministerial support groups*: These are informal ministerial groups that meet weekly or monthly to study together, talk, share, and fellowship together as a source of strength and support. This type of support group seems to be most effective when kept small (six to ten members).²

3. *Team ministries*: This is possible not only in the multiple staff of large churches, but also in “cooperative parishes,” where two or more pastors form a staff for a group of churches, or even arrange for neighboring pastors to work together occasionally in visitation, Bible studies, evangelistic efforts, etc.

4. *Special events*: Retreats, workshops, seminars, campmeetings, social events, picnics, and other events also provide essential social and support resources.

5. *Special lists*: Conferences could provide their ministers with lists of pastoral or professional counselors, psychologists, and psychiatrists with experience in working with ministers.

Congregational Support

What can churches do to support their pastors?

1. *Do not ask or allow a minister to marry the church*: Encourage and praise your

¹Ragsdale, 28.

²Rediger, 156-157.

pastor for taking time off. Respect that time.

2. *Be realistic in your expectations of ministers:* No pastor can meet all the needs of your church; reduce the pressures of the pedestal syndrome.

3. *Be considerate on your demands on the minister's spouse and family:* Be understanding of their problems and appreciative of whatever they are willing to do.

Remember, they have their own lives to live and are not on the conference payroll!

4. *Practice love and grace.*

5. *Include your minister and family in social events:* If you feel comfortable with it, even family events such as Thanksgiving, Christmas, and New Year. Because of their responsibilities many times they have to spend these celebrations far from their families, and they may be feeling lonely.

Professional Resources

1. *Professional counseling:* There is still some resistance to the idea of seeing a professional counselor for help: 68 percent ($N=151$) of the survey respondents indicated that they would see one if needed; 12.2 percent ($N=27$) were not sure, and 19.8 percent ($N=44$) would definitely not see one. It is possible that misunderstanding of some of Ellen G.

White's writings could be one of the reasons behind this resistance.

When in trouble, many think they must appeal to some earthly friend, telling him their perplexities, and begging for help. . . . And all the time there stands beside them the mighty Counselor of the ages, inviting them to place their confidence in Him. . . . Shall we turn from Him to uncertain human beings, who are as dependent upon God as we ourselves are?¹

¹White, *Ministry of Healing*, 512.

Quotations such as the previous one have been taken out of their context or interpreted without searching to discover all she had to say on the topic. A few statements taken alone can lead to a distorted conclusion. Earlier in the same book she had written:

“We are dependent upon one another, closely bound together by the ties of human brotherhood.

“Heaven forming each on other to depend,
a master or a servant or a friend,
bids each on other for assistance call,
till one man’s weakness grows the strength of all.”¹

Roger Coon prepared an excellent compilation of Ellen White’s comments on personal counseling, and ministers would greatly benefit from reading it.²

Here again confidentiality issues are crucial. “Those denominations that rely on counseling networks selected by the denomination have to make special efforts to assure professional leaders that the use of those resources is truly confidential.”³

2. *Career development centers*: These centers provide assistance in clarifying and/or strengthening a person’s relationship to his/her career, providing counseling and support on options of further study, specialization, research, etc. Dr. Benjamin Schoun suggests that an SDA career development center could be established as an adjunct organization of the NAD or the Theological Seminary.⁴

¹Ibid., 494.

²Roger W. Coon, “Ellen White on Personal Counseling,” in *Sourcebook of Documents and Study Outlines of Selected Issues in Prophetic Guidance*, ed. Roger W. Coon (Berrien Springs, MI: Seventh-day Adventist Theological Seminary, 1992).

³Gary L. Harbaugh, *Caring for the Caregiver* (New York, NY: Alban Institute, 1992), 47.

⁴Schoun, *Helping Pastors Cope*, 191.

3. *Psychiatrist/psychologist*: Of the 109 ministers who answered they had experienced depression in the past, 12.8 percent ($N=14$) received medical treatment to overcome their problem. They may have seen doctors or psychiatrists; whatever the case, it is good to know they overcame fears and bias and went to the right place for help.

4. *Insurance coverage*: The North American Division has good health insurance for its ministers and will assist ministers and their families in the expenses related to mental illness, both as inpatient and outpatient, including marital and family counseling.

John Sanford exemplifies the need for support by using the illustration of a sparkling clear lake which stays that way only because it has inlets and outlets. Streams and deep springs flow into it so that it does not dry up, and the outlets are open so that it does not become stagnant and blocked up. There is a receiving and a giving necessary to keep clarity and to foster the life of the lake. So it is with us too. We need to make time for relationships which nurture us and sources that replenish our reservoirs. When these are neglected, our resources are drained and depleted, and we have little social, pastoral, or emotional support to give to others.¹

Financial Resources

What Can the Minister Do?

The Lord expects all of us to be wise managers of the resources He entrusts us with. Although a lot could be said here, just a few basic suggestions could include:

1. *Prepare a monthly budget*: Making sure incomes and expenses balance out, and

¹Sanford, 3-4.

then stick to it!

2. *Include in the budget a portion for saving:* Even if small. It will help you to be prepared for “rainy days.”
3. *Spend realistically, and invest carefully.*
4. *Give careful consideration to taking loans and credit cards:* Be careful with loans and credit cards. Try to avoid both of them to the very best of your abilities.
5. *Attend seminars and workshops:* Special seminars may help you spend and invest in a better way.

What Can Conferences Do?

1. *Do periodical and fair assessments of what the ministers’ salary should be:*
 “Their financial resources should match their economic demands. This may mean increasing salaries or benefits, paying the spouse for work done in the church, or allowing or helping the spouse to find other work,”¹ especially when frequent moves make it difficult for ministers’ spouses to get good jobs, promotions, or other opportunities.
2. *Consider giving salaries to ministers’ wives:* James A. Cress, in his recent article, brought up a point that has been discussed many times in the past within the SDA organization. Should not ministers’ wives who work alongside their husbands receive wages proportionate to the time they spend working for the church?² He quotes several paragraphs from Ellen G. White of which I will select just part of one.

¹Lee and Balswick, 188.

²James A. Cress, “Selective Disobedience,” *Ministry*. June 1998, 28-29.

God is a God of justice, and if the ministers receive a salary for their work, their wives, who devote themselves just as interestedly to the work as laborers together with God, should be paid in addition to the wages their husbands receive, notwithstanding that they might not ask. As the devoted minister and his wife engage in the work, they should be paid wages proportionate to the wages of two distinct workers, that they may have means to use as they shall see fit in the cause of God.¹

Work-related Resources

Changes in Attitudes and Working Habits:

1. *Acknowledge your humanness*: Although this seems obvious, a great deal of unnecessary grief could be averted if ministers would be able to see themselves as human beings.² No minister can survive without accepting his human imperfections and fallibility, and learning to rely, instead, on God's strength, mercy, and forgiveness.
2. *Know your strengths and weaknesses*: If we accept that the diversity of our gifts comes from God, we are obligated to have a clear concept of the nature of these gifts, to know who we are and how and where our talents could be better used.³
3. *Set up realistic expectations of your high calling*: Not denying the importance of ministry and the awesome responsibilities attached to the care of souls, ministers who are especially effective have a great sense of humility about the contribution they personally make and stand in awe of what God does—with or without them! And, because they do not hold exaggerated expectations about their work, they are less likely to become depressed

¹Ellen G. White, *Manuscript Releases* (Silver Spring, MD: E. G. White Estate, 1990), 5:323-324.

²Bratcher, 35.

³*Ibid.*, 134.

when their expectations are not met.¹

4. *Learn that you cannot please everybody:* Do not take criticism as a personal put-down, instead challenge your thinking: If you feel that you are incompetent, this can undermine your self-confidence and make you depressed. To challenge this thinking ask yourself, ‘What is the evidence for the view that I am incompetent? In what areas am I incompetent? Is it OK to be incompetent in some things? How can I become more competent in the areas that matter? When people learn to challenge their own thinking, this can prevent or reduce the severity of depression.²

5. *Learn to listen to others and be flexible in your opinions:* In matters that are not related to biblical principles, or “thus said the Lord,” you can be flexible and find acceptable compromises. This will reduce your levels of frustration.

6. *Learn assertive behavior:* Just as sometimes we need to be flexible and easygoing, other times we need to be assertive in order to handle conflict more constructively and stand up for what is right. Some depression is the consequence of feeling out of control and victimized by other people, which may lead to resentment, anger, loss of self-respect, and depression. Instead of becoming aggressive, resorting to anger to achieve our needs, or passively resigning ourselves to circumstances, we need to learn assertiveness skills. As presented in chapter 2, this need appears to be even greater among Hispanics due to cultural issues and the way Hispanic children are brought up.

¹Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 19-20.

²Collins, 117.

Is there a healthy assertiveness compatible with Christlike behavior? Indeed, there is. “Assertiveness refers to direct and clear expression of one’s thoughts and feelings and desires in a socially appropriate way.”¹ Healthy assertiveness means resolving interpersonal conflicts and differences by standing up for what we believe and expressing our feelings in a non-hostile manner. People with a healthy assertiveness stand up to aggressive people and authority figures without being intimidated, and they do it in a calm, loving, and objective manner. “Learning a healthy assertiveness can help ministers improve communication with others, get them out of a state of helplessness, and free them from a pervasive sense of frustration.”²

7. *Learn to handle your anger:*³ Know how your anger works and manifests itself. Is it leading to headaches, stomach cramps, or tightness in the back of the neck? Does it express itself in moods, gestures, words, or actions? Find a proper time to interpret and self-evaluate your anger. Why are you angry? The evaluation must focus on you, not on the persons or events that caused the anger. Take responsibility for your anger and deal with the factors that are causing your anger. Find ways to express it in appropriate ways. This may include confrontation—and proper communication and assertiveness skills—self-control, reconciliation, and forgiveness.

8. *Develop a biblical balanced theology of both failure and guilt:* We need to be

¹Stephen M. Auerbach and Sandra E. Gramling, *Stress Management: Psychological Foundations* (Upper Saddle River, NJ: Prentice Hall, 1998), 143.

²Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 148.

³Lester, 95-111.

in tune with God's standards and challenge our values and beliefs to be in touch with God's eternal criteria of success—faithfulness. We are called to be obedient, not successful.¹ And just as we teach and preach about God's love and forgiveness, we need to bring our feelings of failure and guilt to God, asking His forgiveness, and learning to forgive ourselves!

9. *Challenge your motives for being a minister:* Are you consciously or unconsciously working for recognition, appreciation, or even to make up for a deficient ego? The minister's motive should be to serve and obey God, and to glorify His name.

If the works of the ambassadors of Christ are wrought in God, they will not be elated by praise from human lips; neither will they be depressed because they think they are not appreciated. Their work is to learn what is the mind of God, that they may show themselves approved unto God.²

10. *Give your spouse and children "permission" to be themselves:* It is important to clarify your expectations of your families by testing them against the reality of God's Word and His plan for their lives. But this must be done in close communication with your family, carefully listening and respecting what they have to say.³

Learn to Manage Your Time:

1. *Set your priorities:* Split your tasks into essential, important, trivial. Focus on the first two and ignore the third.

¹Russell, 5-6.

²Ellen G. White, "In Demonstration of the Spirit," *Advent Review and Sabbath Herald*, August 11, 1891, 1.

³Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 121.

There is the need on occasion for the pastor to strip his schedule to the essentials. The never-ending pileup of things to be done is abetted by the psychology of busyness. Being busy with a myriad of tasks provides us with the security which we seek. It is our most popular antidote to anxiety. Besides being the badge of importance, busyness is also the best defense against doing the things we know we should if we had the time. The prospect of having the time is really quite frightening. Every pastor owes it to his own growth to have this experience.¹

2. *Schedule your tasks for peak efficiency:* Distribute your activities not only according to your priorities but also in harmony with your body's natural rhythm. We all have times at which we are more productive; schedule your tasks around those hours. No one can work at top capacity all the time!

3. *Aim for realistic goals and write them down:* Break work down into smaller tasks that can be tackled one at the time. Remember that if you strive for the impossible, you will almost surely give up. On the other hand, there is nothing like success to breed motivation and nothing like coping to engender feelings of being successful. The genuine feeling of accomplishment that comes from successfully completing a list of realistic work goals can go a long way toward preventing depression in a minister.²

Each day brings its responsibilities and duties, but the work of tomorrow must not be crowded into the hours of today. God is mercifull, full of compassion, reasonable in His requirements. He does not ask us to pursue a course of action that will result in the loss of physical health or the enfeebling of the mental powers. He would not have us work under a pressure and strain until exhaustion follows, with prostration of the nerve.³

¹William E. Hulme, *Your Pastor's Problems* (Garden City, NY: Doubleday, 1966), 147-148.

²Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 119.

³Ellen G. White, *Life Sketches of Ellen G. White* (Mountain View, CA: Pacific Press, 1915), 224.

4. *Sleep on it*: Before you go to sleep, take about five minutes to write down in order of priority the problems you might have the next day. Then ignore them. While you are asleep, your unconscious mind will be hard at work tackling those problems. When you deal with them by rank the next day, you may be surprised at how easily you will be able to work them out.¹

5. *Delegate responsibility*: Sometimes it is tempting to spend time doing things that are more easily accomplished but that could be delegated. Illusions about our own indispensability are among the “ego problems” that prevent us from taking time off.

6. *Say no when necessary*: Learn to say no when asked to do something that would cause us to overextend ourselves beyond our God-given capabilities.²

7. *Give yourself a break*: Allow yourself time for play, free time when you ignore the clock and do not compulsively engage in structured activities.

What Can Conferences Do?

In addition to these, two more suggestions could prove equally valuable.

1. *Train laypeople on the roles, expectations, and limitations of the pastor and his/her family*: Some excellent tools to that end were provided during 1993, the year of the Adventist minister, but ongoing education is needed to help laypeople understand and better support their pastors. This appears to be especially needed among Hispanic congregations who, according to comments made by several ministers in their surveys, appear to be more

¹Insel et al., 28.

²Valenzuela, “The Minister’s Personal and Family Life,” 62-63.

demanding and have higher expectations of their pastors.

2. *Restudy the frequency of pastoral moves:* The stress of moving, both emotional and physical, is significant. Indeed, frequent moves was listed as the second most difficult thing about being in the ministry (table 17). Not being able to put down roots is part of the problem:

Clergy families may adjust by refusing to become too close to people outside their immediate family. . . . The congregation can be an important emotional resource, but if the members of the minister's family are afraid to form close ties with the congregation, they will effectively cut themselves off from this valuable resource.¹

But other problems may include children's academic adjustment to changes in school—particularly if moves are done during school time (several pastors complained specifically about this)—and spouses' changes of job and the financial strain that may cause.

Coping Mechanisms

If you are suffering from depression, remember that there are ways to shorten and alleviate your suffering. Be patient with yourself and give yourself time to deal with this illness, just as you would if you were suffering from cancer or a broken leg. Recovery will take place only after the illness has been appropriately treated.² In addition to the preventive measures suggested—which are also valuable coping mechanisms—here is specific advice for coping with your problem.

1. *Acknowledge your depression and be willing to seek professional help:* Many of us have a great capacity for denial. As long as negatives are not readily visible and the

¹Lee and Blaswick, 194.

²Brain, 144-145.

surface looks good, with little effort we can convince ourselves that everything is all right. “Do you want to get well?” was Jesus’ question of the lame man at the pool of Bethesda (John 5:1-9). Christ’s question was tremendously insightful and helpful. Healing involves an acknowledgment of our problem and a willingness to do what it takes to get well.

2. *If you are having suicidal thoughts:* Just as you would go to see a doctor if you had broken an arm, or to the dentist if you had a terrible toothache, if you are suffering from a serious mental illness you need professional help. Do not postpone it, get help NOW.

3. *Learn as much as you can about depression and its treatment:* “If you suffer from depression, one of your most powerful weapons is knowledge.”¹ Urge your family to learn about depression too. Knowledge will help you recognize the signs and limit the damage depression does to your person and your relationships and it may help you become a partner with your therapist and doctor. Understanding is essential in a time for healing.

Illnesses of the spirit are not healed in the same manner as diseases of the body. A lack of understanding of this fact can be extremely harmful. . . . Some sadness cannot be removed by exchanging funny jokes. Not all forms of loneliness are alleviated by the presence of people. Guilt can remain after the forgiveness of God has been declared. Fear may not be destroyed by the installation of night-lights and burglar alarms. Insecurity often prevails despite prospects for a job with financial income. Trust is not easily or quickly reinstated.²

4. *Learn from past depression:* If you have suffered from depression in the past, learn to identify what has triggered those episodes. Many depressions repeat themselves over and over again. The same incident, word of criticism, or misperceived motive can trigger depression over and over. Analyzing past depressions and learning from them can

¹Quinn, 225.

²Gaddy, 138.

also lead to important discoveries—perhaps there is an endogenous form of depression involved that should be receiving treatment—and could help us avoid them in the future.¹

5. *Understand your own physiology*: Some people have a greater predisposition to fatigue and adrenal exhaustion. Others experience a lowered tolerance for stress and will find themselves therefore in states of distress that can aggravate depression. “We must know ourselves: If we abuse our bodies through overwork, lack of adequate rest, and too much stress, we will pay for it in depression. Accept the limitations of your own particular physiology to eliminate a lot of unnecessary depression.”²

6. *Deal with your guilt*: If there are unconfessed sins in your past, you need to resolve those issues. Sin needs to be confessed and forsaken (1 John 1:9), and God’s forgiveness secured in order to enjoy mental health. If we don’t do it, inner mechanisms go into operation, and these may lead to remorse, depression, or other mental or emotional manifestation.³ But beware! This *does not* mean that if you are suffering from depression it is because there are unconfessed sins in your past! As it has been repeatedly emphasized, many reasons, other than spiritual ones, play a role in the development of depression.

7. *Correct your thought patterns and avoid helplessness*: Helplessness results from a faulty perception that we can do nothing to change circumstances. Paul found the answer to this feeling in Phil 4:13 when he said, “I can do everything through him who gives

¹Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 144.

²Ibid., 144-145.

³Osborne, 106-107.

me strength.” Furthermore, “we can alleviate the state of helplessness by the simple act of ‘taking control.’ Merely moving into *some* active mode, can give one a feeling that control is being restored. This mobilizes the resources from God and from within to deal with crisis situations.”¹

But, if you are severely depressed it may be difficult—if not impossible—to get problems off your mind and to change your thought patterns on your own. If you try, you may fail and feel guilty, ashamed, and even more depressed. If that is your case do not hesitate to find professional help.

Consider this: If you broke your leg, would you beat yourself up for not being able to walk on it right after you broke it? Would you think yourself weak? Would you think there is something wrong with you as a person? Trying to force yourself to ‘get on with your life’ and failing when you are severely depressed is no more a reflection on you as a person than is your inability to walk on a broken leg.²

8. *Take time for relationships:* Do not underestimate the importance of social and support systems to help you out of your crisis.

9. *Trust in God:* God may still bring something good out of this! People who have never hurt, who have only known health, success, and happiness are typically insensitive to sadness, failure, and sickness and can be intolerant of people plagued with those problems. They are often quick at passing judgments and have a poor understanding of the complex makeup of human nature and the infinite compassion of the divine nature. Only in hurting

¹Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 145.

²Quinn, 50.

do many of us find out what life is really like.¹ Ministers can make their own wounds available as a source of healing to others and through their own pains be better able to heal another's. As Robert Raines put it: "Our wounds are the visa into the country of another person's deep being."²

What Can Conferences Do?

Conferences can best help by showing an open attitude and supporting the minister in every possible way. When the crisis is over, the minister will not only be a productive employee again, but he/she will probably be more valuable because of his/her increased perspective and deeper understanding of human sufferings.³ Other help may include encouragement to seek the appropriate treatment, suggestions of further education or training, the possibility of a job/district change, or offers of a sabbatical. Understanding, love, and concern will undoubtedly be the greatest help that any employer can give.

What Can the Family Do?

Dr. Archibald Hart suggests several family strategies for turning depression into a growth experience.⁴ Among these, I would like to point out the following ones:

1. At the earliest opportunity, a family conference should be called in which the

¹Gaddy, 143.

²Robert Raines, quoted in Leavitt, 16.

³Conway, 276.

⁴Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 129-133.

facts of the depression are frankly discussed and the need for commitment to a determined effort to work it out is stressed.

2. Family members must be helped to accept the depression as a reality, and the problem must be perceived as a family concern.

3. Every member of the family must be supportive of the treatment.

4. Family responsibilities should be rearranged for the duration of the depression.

5. Family prayer and spiritual support will be an important source of strength through this difficult time.

When the Minister's Spouse Is Depressed

Although this is not the topic of this dissertation, due to the fact that several survey respondents mentioned how much they would appreciate a similar study for ministers' spouses, a few comments regarding this issue are added here.

There are many reasons why a minister's spouse could become depressed. Some may be related to the interaction between the family and the minister's vocation, others to personal tensions between the minister and the spouse, and others still to endogenous or physical factors. Depression in a minister's spouse can have a debilitating effect on the pastor. He or she will have to compensate for the spouse's diminished activity and will also be subjected to much additional stress. The spouse may use the minister as a scapegoat and blame the ministerial job for the way he or she feels. On the other hand, the minister may not be very understanding of the depression and may demand more from the spouse than he or she can provide. In these situations the potential for conflict is extremely high, and

professional help should be considered.¹

Curative Alternatives

Depression has been considered by many as a self-limiting disease. That is, left to itself, it would run its course, and then you would return to normal. That appears to be true in only a minority of cases. Someone suffering from a first episode of depressive illness will likely get somewhat better over time without treatment, although he/she will suffer more, and it will take longer to get better. But many patients are left with residual symptoms after a depressive episode and these patients are much more likely to have another episode. Subsequent episodes are likely to be more severe and resistant to treatment.²

When to Seek Professional Help

A minister who would readily seek medical help for a physical problem is often reticent to seek specialized help for a mental problem. But “when a person is clearly losing his or her grip on life, experiencing painful emotions which may be incapacitating, becoming ineffective in work, and destructive in interpersonal relationships, it is time for professional help.”³ Depression that is severe, has lasted more than a month, or is experienced repeatedly should be treated by a professional; and the sooner treatment of severe

¹Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 132.

²Quinn, 24.

³Hart, *Coping with Depression in the Ministry and Other Helping Professions*, 100.

depression begins, the shorter its duration will be.¹

Where Should Depression Be Treated?

This will depend on the nature and severity of the problem.

1. The first step may be to see the “family doctor” or usual health-care provider. He/she can diagnose depression and ask questions to find out if depression may be caused by physical causes and can provide referrals to mental-health specialists if needed.
2. Help for depression is available through: community mental-health centers, state and local health departments, employee assistance programs (EAPs), hospitals, clinics, and private practices.
3. Most patients can be effectively treated on an outpatient basis. The patient can continue with his or her normal daily routine. Hospitalization is necessary only when a patient is an immediate danger to him or herself or others.²
4. Mild depressions can be handled by a competent counselor with at least a master’s degree in counseling. Clinical social workers and experienced pastoral counselors may also work effectively with this type of problem.
5. More serious depressions and those that appear to be repetitive should be treated by a clinical psychologist or a psychiatrist experienced in working in a hospital setting and with severely disturbed patients.
6. Do not take suicidal thoughts lightly, seek professional help immediately.

¹Quinn, 24-25.

²Ibid., 113-114.

7. Whenever possible, seek treatment by someone who understands and shares the Christian faith. This can make a big difference in the level of trust and rapport between patient and therapist, and in the type of mechanisms advised for recovery. Unfortunately, not every Christian professional is necessarily competent or skilled to deal with your particular problem, and they may not be readily available. It may be necessary, therefore, to see someone who is not a Christian believer. If the professional is obviously competent, then this should not be a hindrance. However, if he or she appears to be antagonistic toward Christianity, it is probably best to see someone else.

Additional information on sources of information and treatment of depression can be found in appendix D.

Types of Professional Treatments Available

Depressive illness is generally best treated with a combination of medication and psychotherapy. Other methods of treatment include bright-light therapy, nutritional approaches, dietary supplements, and other promising alternatives.¹

Medication

Antidepressant drugs are relatively recent in origin; they were introduced about 1955. Since then, however, they have revolutionized the treatment of severe depressions. They provide the most widely used method of treating those depressions which are suspected of having biological causes.² Some of the most frequently prescribed ones

¹Ibid., 22.

²Whybrow, 262.

include: Trazodone (Desyrel), Amoxapine (Asendin), Fluoxetine (Prozac), and Bupropion (Wellbutrin).¹

A common misconception is that antidepressive medication is only for crazy people who cannot function. Nothing could be further from the truth. If you suffer from depression or take medication for it, you are no more crazy than is someone who takes insulin for diabetes. Both diabetes and depression are physical illnesses. You need not feel any shame or embarrassment about treating depression with medication.²

A variety of medications can help relieve depression's symptoms and restore a person to normal functioning, and none of them are habit-forming or addictive.³ Still, psychiatric medications usually evoke fears of being "drugged," "doped up," and being unable to function or think clearly. Some of these effects may occur when the medication is used incorrectly, and an important part of a psychiatrist's function is to watch carefully for these side effects and to make appropriate changes to find the right medication/s for each individual.⁴ People differ greatly in their responses to medication. Sometimes a combination of drugs is most effective, so more than one may be prescribed. A critical issue here is the importance of sticking to the treatment until the right medications are found.

¹Klein and Wender, 134-138.

²Quinn, 22-23.

³Many authors present detailed explanations of various antidepressant drugs currently available, among them Whybrow, 261-267; and Maurizio Fava and Jerrold F. Rosenbaum, "Pharmacotherapy and Somatic Therapies," in *Handbook of Depression*, ed. E. Edward Beckham and William Leber (New York, NY: Guilford, 1995), 280-301.

⁴Charry, 84.

Psychotherapy

As it was mentioned before, medication works better when accompanied with psychotherapy. In this context a trained expert helps people to explore the contributing factors and effects of their depression. Common methods include:¹

1. *Interpersonal Therapy (IPT)*: This treatment focuses on how a person's relationships may contribute to and be affected by depression. It seeks to explore and improve the person's relationships.
2. *Cognitive/Behavioral Therapy (CBT)*: This treatment helps the person examine troubled thoughts and actions. The goal is to help change the way the person thinks about and interacts with the world.
3. *Psychoanalytic Psychotherapy for Depression (PPD)*: This treatment is founded on the idea that depression is based on childhood disappointments of wishes for parental affection and affirmation.
4. *Biologically Informed Psychotherapy of Depression (BIPD)*: This therapy treats biologically based, genetically transmitted depressive illness.

Therapy settings may also vary; for example, patients may benefit from:

1. *Individual Therapy*: This involves one-on-one talks with a therapist.
2. *Marriage or Family Therapy*: The person with depression participates with his or her loved ones.
3. *Group Therapy*: One or more facilitators helps a group of people improve their mental health and the quality of their relationships.

¹Quinn, 114-120.

4. *Self-help Groups*: In this therapy, people meet to discuss common issues.

Other Methods of Treatment

In special cases, treatment for depression may include:

1. *Hospitalization*: If a depressed person's health or safety is in danger, a hospital stay may be necessary. A brief stay in a hospital environment can be very effective in stopping a "runaway" or spiraling depression. Being removed from the pressures of work and routine duties can relieve the apprehension and anxiety accompanying severe depression and establish a more solid foundation for continued treatment.

2. *Light Therapy*: Treatment for seasonal affective disorder may include exposure to a special light that simulates daylight.

3. *Electroconvulsive Therapy*: First used in Italy during the late 1930s, ECT became widespread as a treatment procedure after World War II. While the advent of antidepressant medication has reduced the need for ECT, it is still the most effective and efficient treatment for moderate to severe depression. Despite misinformation given to the public through the melodrama of books, TV, and the movies, ECT remains a reliable, effective, and quick way of treating severe depression, and most of the serious side effects associated with ECT in the past have been eliminated by modern techniques.¹

4. *Natural compounds*: B vitamins, minerals, essential fatty acids, and medicinal plants, among others, have been found to be helpful in treating depression.

¹Klein and Wender, 115-117.

How Effective Are the Treatments Now Available?

Therapy for depression can show results quickly, usually in a matter of weeks.

Learning skills for coping in the future, on the other hand, should be a continuous personal growth area. Biological treatments for depression are dramatically effective. Eighty percent, or even more, of individuals suffering from major depression will respond to one or another of the antidepressant drugs, singly or in combination.¹ On the other hand, there is mounting evidence that cognitive therapy is also an effective, short-term treatment for adult outpatients with nonbipolar depression.²

Just as Job was used mightily by God *after* his time of depression, just as Elijah's emotional breakdown did not prevent him from being a valuable servant of God and one of the greatest prophets of all times, just as Moses, David, and other men and women of God were able to overcome depression, so can any of us who is experiencing this illness. From the way God dealt with Elijah's depression we can learn that "God really cares for us and that crises through which we may go are just that—temporary crises in which we can count on the ministry of God from many different sources, so that we again become people who enjoy living and enjoy ministering."³

Limitations of This Study and Further Areas of Research

Although the expectations and limitations of this research were described in

¹Ibid., 105.

²David H. Barlow, *Clinical Handbook of Psychological Disorders* (New York, NY: Guilford, 1993), 275.

³Conway, 299.

chapter 1, it is important to clarify once again that this study was prepared to apply specifically to SDA Hispanic ministers in the North American Division, and although general literature may provide evidence that similar principles may apply in other countries, or other denominational situations, they would need to be assessed separately.

Further research comparing findings of this study to those of other ethnic groups, other countries or across denominations, could be very valuable. Statistical analysis and levels of correlations between variables could also be conducted. Additional studies on Hispanic ministers' expectations and where they derive their satisfaction from could also prove insightful.

Conclusion

“Health in the true sense means wholeness. To be whole is to have all the resources of life functioning together in a balanced proportion.”¹ This was probably what Jesus meant by abundant life in the context of His words, “I have come that they may have life, and have it to the full” (John 10:10).

God is the main reservoir of strength for physical, intellectual, emotional, social, and spiritual health. His promise never to leave us or forsake us—even when we go through the valley of the shadow of death—is worth holding on to, especially when one is contending with feelings of discouragement or depression. But He expects in this—as in every other aspect of our lives—our proactive participation by making wise use of all resources that He has made available to us to prevent and/or overcome depression.

¹Paul E. Johnson, “The Emotional Health of the Clergy,” *Journal of Religion and Health* 9 (January 1970): 51.

This research is expected to create awareness and a better understanding of the problem of depression, breaking down taboos about the topic while presenting its realities. It is hoped that the information provided may become a practical guide for all ministers, stimulating a more open discussion about the topic, helping to implement all viable means to alleviate this problem, and giving us new insights that may help all of us when dealing with depression among our church members.

As ministers, in the course of our lifetime we will have the privilege and challenge of touching countless lives in a highly personal and profound way, but we should not forget to allow ourselves to be cared for and ministered to as well. Each investment in the physical, intellectual, emotional, social, and spiritual health of our own lives will touch many others.¹ So our greatest challenge is to learn how to “burn ourselves” in the service of the Lord without being consumed, how to care for ourselves in addition to caring for those God has entrusted to us, how to keep our lives in harmony by balancing work with rest, and how to keep physically and psychologically healthy through recreation, disciplined living, forgiveness, and supportive relationships. That is the critical balance of pastoring!

¹Miller and Jackson, 466.

APPENDICES

APPENDIX A

LETTERS

- **Dr. Eradio Alonso's Letter of Introduction**
- **Personal Letter of Introduction**
- **Follow-up Letters (3)**
- **Letter to Conferences Requesting Information on Support Resources Available to Ministers**

Ministerial Association

12501 Old Columbia Pike
Silver Spring, Md. 20910
301-440-6000 USA
Telex: 917 100 100
Cable: 917 100 100**Diciembre 3, 1997****Queridos colegas:**

Pocas veces tenemos la oportunidad de recibir una mano amiga o un consejero fiel que nos ayude en nuestros momentos de prueba, de soledad o de depresión. Gracias a Dios, recomendado por el Dr. Alfonso Valenzuela, quien es el presidente de su comité doctoral y el pastor Luis Leonor, vice presidente de la Unión del Lago, quiero aprovechar la oportunidad para recomendarles cooperar con el pastor Enrique Calandra en su estudio sobre la sintomatología de la depresión ministerial. Este proyecto meritorio y único en su clase, nos ayudará a todos los que compartimos el llamado y las grandes responsabilidades ministeriales, a mantenernos dentro de los límites de una salud mental y emocional, personal y familiar positiva, que resulten en un ministerio más poderoso y fecundo. Este estudio, creemos sinceramente, nos ayudará a evitar tanto dolor, frustración y tormento emocional a niveles traumatizantes que conspiran contra el ministerio de Jesucristo.

Quisiera pedirles a todos ustedes que saquen de su ocupado itinerario y apretado y plan de trabajo, un tiempo para rellenar el cuestionario que va adjunto a nuestra carta. Tomemos esta oportunidad para ayudar al pastor Calandra en su noble tarea de ayudar al ministerio hispano a detectar los síntomas depresivos, superarlos exitosamente y así evitar el dolor al ministro, su familia y la Iglesia de Jesucristo.

De ustedes en Cristo con agradecimiento,

Eradio Alonso

jt

FIELD(1) FIELD(2)
 FIELD(3)
 FIELD(4)

22 de diciembre de 1997

Apreciado pastor FIELD(2):

Como pastor adventista, master en aconsejamiento y alumno doctoral del Seminario Teológico de la Universidad Andrews estoy conduciendo un estudio entre los pastores hispanos de la División Norteamericana bajo la supervisión del Dr. Alfonso Valenzuela.

Los dos cuestionarios adjuntos nos ayudarán a identificar la existencia o no de sintomatología depresiva entre los pastores adventistas hispanos, el grado de profundidad de dicha sintomatología y posibles causas de los resultados que se obtengan.

Quisiera rogarle que separe un tiempito—de 15 a 30 minutos—para contestar ambos cuestionarios y que los envíe lo antes posible en el sobre estampillado adjunto. Su respuesta será de suma importancia ya que este esfuerzo conjunto nos permitirá conocer mejor el nivel de salud emocional entre los pastores adventistas hispanos y nos ayudará grandemente en la preparación de seminarios y programas que apunten a buscar soluciones prácticas y positivas para los problemas existentes y nos permitan desarrollar un ministerio más efectivo y poderoso.

Aun cuando el estudio cuenta con el apoyo completo de la organización, quisieramos enfatizar que los cuestionarios no están codificados y sus respuestas serán totalmente confidenciales y vistas solamente por los abajo firmantes. Puede enviar sus respuestas en forma anónima o, si desea que le enviemos los resultados de la Escala de Zung de Sintomatología Depresiva, puede colocar su nombre. Sea cual fuere su decisión, tenga la seguridad que este estudio se conducirá con seriedad y total respeto por su privacidad.

¡Nuevamente gracias por su tiempo y su cooperación! Le rogamos tenga a bien responder a más tardar el 31 de enero. Si tiene preguntas, o puedo servirle de alguna manera, será un placer conversar con usted al (616) 471-6730 de 8 a 10 p.m. (hora del este).

Sinceramente,

Enrique N. Calandra
 Candidato a D.Min, Universidad Andrews
 y Director de Capellanes de AIM
 (Adventist Information Ministry)

Alfonso Valenzuela, Ph.D.
 Profesor y Director Asociado del
 Instituto de Ministerios Hispanos
 Seminario Teológico, Universidad Andrews

FIELD(1) FIELD(2)
 FIELD(3)
 FIELD(4)

16 de enero de 1998

Apreciado pastor FIELD(2):

Tres semanas atrás le enviamos una carta comentándole del estudio que estamos realizando entre los pastores hispanos de la División Norteamericana como parte de mi tesis doctoral y bajo la supervisión del Dr. Alfonso Valenzuela. Este estudio nos ayudará a identificar la existencia o no de sintomatología depresiva entre los pastores adventistas hispanos, el grado de profundidad de dicha sintomatología y posibles causas de los resultados que se obtengan.

Si usted ya envió los dos cuestionarios de regreso, ¡muchas gracias por su aporte a este importante estudio! y por favor no haga caso a los cuestionarios adjuntos. Si aún no tuvo ocasión de completarlos—¡sabemos que la época de fiestas navideñas y de fin de año es muy atareada!—aquí le adjuntamos un segundo juego de cuestionarios y le rogamos que tome un tiempito para contestarlos lo antes posible.

Ya hemos recibido un buen número de respuestas y contamos también con la suya para que este estudio sea realmente representativo de la totalidad de los pastores hispanos de esta División. Como le dijéramos en la carta anterior, este esfuerzo conjunto nos permitirá conocer mejor el nivel de salud emocional entre los pastores adventistas hispanos y nos ayudará en la preparación de seminarios y programas que apunten a buscar soluciones prácticas para los problemas existentes y nos permitan desarrollar un ministerio más efectivo.

Una vez más quisiéramos enfatizar que los cuestionarios no están codificados y sus respuestas serán totalmente confidenciales y vistas solamente por los abajo firmantes. Puede enviar sus respuestas en forma anónima o, si desea que le enviemos los resultados de la Escala de Zung de Sintomatología Depresiva, puede colocar su nombre. Sea cual fuere su decisión, tenga la seguridad que este estudio se conducirá con seriedad y total respeto por su privacidad.

¡Feliz Año Nuevo y GRACIAS por su tiempo y su cooperación! Le rogamos tenga a bien responder a más tardar el 31 de enero. Si tiene preguntas, o puedo servirle de alguna manera, será un placer conversar con usted al (616) 471-6730 de 8 a 10 p.m. (hora del este).

Sinceramente,

Enrique N. Calandra
 Candidato a D.Min, Universidad Andrews
 y Director de Capellanes de AIM
 (Adventist Information Ministry)

Alfonso Valenzuela, Ph.D.
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 Seminario Teológico, Universidad Andrews

7 de febrero de 1998

Apreciados colegas:

Ésta es la última carta que recibirán de nosotros solicitando su colaboración en el estudio de sintomatología depresiva entre los pastores hispanos de la División Norteamericana.

Si usted ya envió los dos cuestionarios de regreso, ¡muchas gracias por su aporte a este importante estudio! y por favor no haga caso de esta carta. Si aún no tuvo ocasión de completar los cuestionarios, quisiéramos rogarle que lo haga lo antes posible. Sólo podremos tomar en cuenta las respuestas que recibamos antes del 28 de febrero ya que después de eso estaremos procesando toda la información.

Ya hemos recibido aproximadamente un 50% de las respuestas, pero contamos también con la suya para que este estudio sea realmente representativo de la totalidad de los pastores hispanos de esta División. Recuerde que puede enviar sus respuestas en forma anónima o, si desea que le enviemos los resultados de la Escala de Zung de Sintomatología Depresiva, puede colocar su nombre. Sea cual fuere su decisión, tenga la seguridad de que este estudio se conducirá con seriedad y total respeto por su privacidad.

¡Feliz Año 1998 y GRACIAS por su tiempo y su cooperación! Si tiene preguntas, o puedo servirle de alguna manera, será un placer conversar con usted al (616) 471-6730 de 8 a 10 p.m. (hora del este).

Sinceramente,

Enrique N. Calandra
Candidato a D.Min, Universidad Andrews
y Director de Capellanes de AIM
(Adventist Information Ministry)

Alfonso Valenzuela, Ph.D.
Profesor y Director Asociado del
Instituto de Ministerios Hispanos
Seminario Teológico, Universidad Andrews

FIELD(1) FIELD(2)
 FIELD(3)
 FIELD(4)

Date

Apreciado pastor FIELD(2):

Muchas gracias por mostrar interés y tomar el tiempo para contestar los cuestionarios que le enviáramos para el estudio sobre sintomatología depresiva entre los pastores hispanos de la División Norteamericana.

Adjunto encontrará sus resultados personales y confidenciales de la Escala de Zung de Sintomatología Depresiva. Quisiera aclararle que esto NO es un diagnóstico, sino simplemente uno de diversos métodos que miden la sintomatología depresiva. Más adelante estaremos sacando una serie de artículos en la revista Ministry presentando los resultados generales de este estudio junto con información y sugerencias importantes relacionadas con el tema de la depresión en el ministerio.

Si la puntuación de sus resultados indica que está experimentando algún grado de depresión, quisiera sugerirle que vaya a ver a su médico lo antes posible, ya que él podrá darle un diagnóstico definido y el tratamiento adecuado. Por otro lado, si usted pensó que estaba depresivo pero sus resultados lo colocan dentro de la escala de lo normal, los artículos a salir servirán para aclarar algunos conceptos y precisar ideas sobre el tema.

¡Nuevamente gracias por su tiempo y cooperación! Si puedo servirle de alguna otra manera, será un placer conversar con usted al (616) 471-6730 de 8 a 10 p.m. (hora del este).

Sinceramente,

Enrique N. Calandra
 Candidato a D.Min, Universidad Andrews
 y Director de Capellanes de AIM
 (Adventist Information Ministry)

Berrien Springs, MI
March 2, 1999

Elder FIELD(firstn) FIELD(lastn)FIELD(position)
FIELD(conference)
FIELD(streeta)
FIELD(city)

Dear Elder FIELD(lastn):

As a part of my dissertation for the DMin program at Andrews University, I conducted a survey among all Hispanic pastors of the North American Division regarding "Depressive Symptomatology among Hispanic Ministers of the North American Division." This research was conducted under the supervision of Dr. Alfonso Valenzuela, professor at the Adventist Theological Seminary, and had the support of Dr. Eradio Alonso, Hispanic Ministerial Director of the North American Division.

The data found on this research is very interesting and will be presented in a couple of articles in the *Ministry* magazine. Although the study was conducted among Hispanic pastors, the insights gained through the research may prove valuable for ministers across ethnic backgrounds.

Among the appendices of my dissertation I would like to include a section on the resources that each local conference has made available to assist/support pastors with their mental/emotional health. I am interested both in preventive and remedial resources available at the FIELD(conference). I would really appreciate your participation in this research by completing and mailing the enclosed form by April 10.

Thank you, and may God bless you!

Sincerely,

Enrique N. Calandra

APPENDIX B

SURVEY INSTRUMENTS

- **Zung SDS Scale
(In Spanish and English)**
- **Questionnaire for Pastors
(In Spanish and English)**
- **Support Resources Available to Ministers
at the Conference Level**

Instrucciones:

Lea cada declaración cuida dosamente. Para cada declaración, marque el círculo de la columna que mejor responda a la forma como usted se ha sentido durante las últimas dos semanas.

Para las declaraciones 5 y 7, si usted está a dieta, conteste como si no lo estuviera.

Por favor, señale una respuesta de cada una de las siguientes declaraciones

		Nunca o Muy Pocas Veces	Algunas Veces	Frecuen- temente	La Mayoría del Tiempo o Siempre
1	Me siento descorazonado, melancólico y triste	☐	☐	☐	☐
2	Por la mañana es cuando mejor me siento	☐	☐	☐	☐
3	Siento deseos de llorar	☐	☐	☐	☐
4	Me cuesta trabajo dormir durante la noche	☐	☐	☐	☐
5	Como tanto como solía comer antes	☐	☐	☐	☐
6	Disfruto conversando, mirando y estando con mujeres/hombres atractivos	☐	☐	☐	☐
7	Noto que estoy perdiendo peso	☐	☐	☐	☐
8	Tengo problemas de estreñimiento	☐	☐	☐	☐
9	Mi corazón late mas rápidamente que lo normal	☐	☐	☐	☐
10	Me canso sin motivo	☐	☐	☐	☐
11	Mi mente esta tan despejada como siempre	☐	☐	☐	☐
12	Me resulta fácil hacer todo lo que solía hacer	☐	☐	☐	☐
13	Me siento intranquilo y no puedo mantenerme quieto	☐	☐	☐	☐
14	Tengo esperanzas en el futuro	☐	☐	☐	☐
15	Me irrito mas de lo normal	☐	☐	☐	☐
16	Encuentro fácil el tomar decisiones	☐	☐	☐	☐
17	Siento que me necesitan y que soy útil	☐	☐	☐	☐
18	Llevo una vida satisfactoria	☐	☐	☐	☐
19	Siento que los demas estarían mejor si yo estuviese muerto	☐	☐	☐	☐
20	Todavía disfruto de las cosas que solía hacer	☐	☐	☐	☐

Instructions

Read each sentence carefully. For each statement, check the bubble in the column that best corresponds to how often you have felt that way during the past two weeks.

For statements 5 and 7, if you are on a diet, answer as if you were not.

Please check a response for each of the 20 items.		None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1	I feel downhearted, blue, and sad	☐	☐	☐	☐
2	Morning is when I feel the best	☐	☐	☐	☐
3	I have crying spells or feel like it	☐	☐	☐	☐
4	I have trouble sleeping through the night	☐	☐	☐	☐
5	I eat as much as I used to	☐	☐	☐	☐
6	I enjoy looking at, talking to, and being with attractive women/men	☐	☐	☐	☐
7	I notice that I am losing weight	☐	☐	☐	☐
8	I have trouble with constipation	☐	☐	☐	☐
9	My heart beats faster than usual	☐	☐	☐	☐
10	I get tired for no reason	☐	☐	☐	☐
11	My mind is as clear as it used to be	☐	☐	☐	☐
12	I find it easy to do the things I used to do	☐	☐	☐	☐
13	I am restless and can't keep still	☐	☐	☐	☐
14	I feel hopeful about the future	☐	☐	☐	☐
15	I am more irritable than usual	☐	☐	☐	☐
16	I find it easy to make decisions	☐	☐	☐	☐
17	I feel that I am useful and needed	☐	☐	☐	☐
18	My life is pretty full	☐	☐	☐	☐
19	I feel that others would be better off if I were dead	☐	☐	☐	☐
20	I still enjoy the things I used to do	☐	☐	☐	☐

CUESTIONARIO PARA PASTORES

- I. Evalúe lo más honestamente posible si tiene muy poco, poco, lo justo, mucho, o demasiado de los siguientes elementos en su vida: Simplemente **circule** un número en la escala de 1 a 6 en cada respuesta.

	MUY POCO		LO JUSTO		DEMASIADO	NO APLICA
* Cantidad de ejercicio físico que practico	1	2	3	4	5	6
* Crecimiento profesional	1	2	3	4	5	6
* Amistad	1	2	3	4	5	6
* Tiempo que paso con my esposo/a	1	2	3	4	5	6
* Vacaciones y tiempo libre	1	2	3	4	5	6
* Recursos financieros (sueldo y/u otras entradas)	1	2	3	4	5	6
* Tiempo que paso con mis hijos y/u otros miembros de familia	1	2	3	4	5	6
* Intimidad / Vida sexual	1	2	3	4	5	6
* Oración y meditación	1	2	3	4	5	6

- II. ¿Cuán satisfecho está usted con los siguientes aspectos de su vida? **Circule** un número del 1 al 6 expresando si está muy contento, contento, satisfecho, desconforme, o muy desconforme:

	MUY CONTENTO		MUY SATISFECHO		DESCONFORME	NO APLICA
* El tiempo que paso en actividades recreativas o hobbies	1	2	3	4	5	6
* Mi relación con mis superiores	1	2	3	4	5	6
* La oportunidad de crecimiento educativo que me da mi conferencia	1	2	3	4	5	6
* La comunicación con mi esposo/a	1	2	3	4	5	6
* Mi salario/sueldo	1	2	3	4	5	6
* El aprecio que mi congregación muestra por mi trabajo	1	2	3	4	5	6
* El tiempo que paso cultivando mi propia vida espiritual	1	2	3	4	5	6
* El apoyo social de mis amigos y familia	1	2	3	4	5	6
* La confianza y respeto de mi esposo/a	1	2	3	4	5	6
* El nivel educativo que pude alcanzar	1	2	3	4	5	6
* La manera como trato a mi esposo/a	1	2	3	4	5	6
* Mi esposo/a trabaja fuera del hogar	1	2	3	4	5	6
* El nivel de espiritualidad en nuestra familia	1	2	3	4	5	6

CUESTIONARIO PARA PASTORES

III. ¿Cuán firmemente concuerda o disiente (no está de acuerdo) con las siguientes declaraciones?
Circule un número en la escala del 1 al 6 expresando si concuerda firmemente, concuerda, no sabe, disiente, o disiente firmemente.

	CONCUERDO FIRMEMENTE		NO SE	DISIENTO FIRMEMENTE		NO APLICA
* Mis superiores están contentos con mi trabajo.	1	2	3	4	5	6
* Mi esposo/a disfruta de trabajar fuera del hogar.	1	2	3	4	5	6
* Me resisto a compartir mis problemas con otros por temor a que mis asuntos privados se vuelvan públicos.	1	2	3	4	5	6
* Me alimento con una dieta balanceada.	1	2	3	4	5	6
* El ministerio ocasiona gran estrés para mi familia.	1	2	3	4	5	6
* He considerado seriamente la posibilidad de abandonar el ministerio.	1	2	3	4	5	6
* Si lo necesitase, no dudaría en ver a un consejero profesional.	1	2	3	4	5	6
* Estoy contento/a con mi matrimonio.	1	2	3	4	5	6
* A menudo me siento solo/a.	1	2	3	4	5	6
* Me siento feliz en el ministerio.	1	2	3	4	5	6
* Mi esposo/a siente que cumple con las expectativas de la congregación.	1	2	3	4	5	6
* Me siento cómodo/a buscando apoyo de la administración de la conferencia para problemas personales delicados.	1	2	3	4	5	6
* Los problemas y conflictos de mi/s iglesia/s me afectan personalmente.	1	2	3	4	5	6
* Mi esposo/a apoya mi ministerio.	1	2	3	4	5	6
* Creo que debo pedir consejo solamente a Dios cuando estoy experimentando problemas personales.	1	2	3	4	5	6
* Necesito aprender a administrar mejor mi tiempo.	1	2	3	4	5	6
* Tengo colegas pastores con los que me siento cómodo/a compartiendo mis problemas personales.	1	2	3	4	5	6
* Hay un espíritu de competencia entre los pastores de mi conferencia.	1	2	3	4	5	6
* Temo que mi reputación y mi trabajo puedan verse amenazados si comparto mis problemas con otros.	1	2	3	4	5	6
* No tengo a quién recurrir cuando me siento desanimado/a y solitario/a.	1	2	3	4	5	6
* El tener más oportunidades para trabajar y establecer relaciones con otros pastores sería muy beneficioso para mi ministerio.	1	2	3	4	5	6
* Considero que un poco de tiempo libre adicional, como un periodo de sabático, me ayudaría a sentirme mejor.	1	2	3	4	5	6

CUESTIONARIO PARA PASTORES

IV. Por favor, conteste las siguientes preguntas tan honestamente como le sea posible, marcando el casillero apropiado.

	SÍ	NO	NO APLICA
* ¿Trabaja normalmente más de 45 horas por semana?	☐	☐	☐
* ¿Tiene deudas por un total de más de \$10.000? (Excluyendo la hipoteca de su casa)	☐	☐	☐
* ¿Cree que tomó la decisión correcta al entrar en el ministerio?	☐	☐	☐
* ¿Se siente cómodo/a con las expectativas que la Iglesia Adventista tiene de usted?	☐	☐	☐
* ¿Duerme un mínimo de 7 horas por noche?	☐	☐	☐
* ¿Comparte con su esposo/a la responsabilidad de la educación y disciplina de sus hijos?	☐	☐	☐
* ¿Se toma el día libre semanal para descansar y estar con su familia?	☐	☐	☐
* En los últimos 10 años, ¿se mudó más de 2 veces?	☐	☐	☐
* ¿Va al médico para realizar su chequeo regular?	☐	☐	☐
* ¿Tiene deudas por un total de menos de \$10.000? (Excluyendo la hipoteca de su casa)	☐	☐	☐
* ¿Hay algún miembro de su familia (esposa, hijos) seriamente enfermo?	☐	☐	☐
* ¿Tiene algún familiar que sufre de depresión?	☐	☐	☐
* ¿Se desanima fácilmente?	☐	☐	☐
* ¿Alguna vez intentó suicidarse?	☐	☐	☐
* ¿Cree que está experimentando algún grado de depresión en estos momentos?	☐	☐	☐
* Si respondió que sí a la pregunta anterior, puede señalar la/s razón/es principal/es? (Marque todas las que apliquen)			
☐ Problemas familiares	☐ Problemas financieros		
☐ Problemas de salud	☐ Otras/ Por favor, explique: _____		
☐ Problemas relacionados con el trabajo			
* ¿Ha experimentado depresión en el pasado?	☐	☐	☐
* Si respondió que sí a la pregunta anterior, puede señalar la/s razón/es principal/es? (Marque todas las que apliquen)			
☐ Problemas familiares	☐ Problemas financieros		
☐ Problemas de salud	☐ Otras / Por favor, explique: _____		
☐ Problemas relacionados con el trabajo			
* ¿Qué le ayudó a superar su depresión en el pasado? (Marque todas las que crea que aplican)			
☐ Tratamiento médico	☐ El apoyo de sus amigos		
☐ Mejores hábitos de salud	☐ Una vida devocional más consecuente		
☐ El apoyo de su familia	☐ El resolver problemas que acarrea del pasado		
☐ Aconsejamiento	☐ Otras / Por favor, explique: _____		
* ¿Ha experimentado alguna de las siguientes situaciones durante los últimos 12 meses?			
☐ Muerte del esposo/a	☐ Matrimonio		
☐ Divorcio/separación matrimonial	☐ Mudanza/cambio de distrito pastoral		
☐ Muerte de un familiar cercano	☐ Accidente o enfermedad personal seria		
☐ Enfermedad seria de algún familiar cercano			

CUESTIONARIO PARA PASTORES

Las siguientes datos nos ayudarán a entender cómo diferentes grupos de ministros ven las cosas. Le rogamos que las complete con la seguridad de que esta información, así como su identidad—si decide compartirla con nosotros—será guardada bajo la más estricta reserva y manejada solamente por el alumno doctoral y su consejero. La seriedad y sensibilidad de este estudio demanda que manejemos la información que usted amablemente nos proveerá con el más alto grado de confidencialidad.

Nombre: _____

(Optativo: Solamente si desea los resultados de la Escala de Zung de Sintomatología Depresiva).

Edad: _____

Lugar de nacimiento:

☐ Islas del Caribe

☐ México

☐ Sudamérica

☐ España

☐ Interamérica (excluyendo México)

☐ Otro: _____

Nivel educativo más elevado que alcanzó o está en proceso de alcanzar:

☐ BA in Teología

☐ Maestría

☐ M.Div

☐ D.Min

☐ EdD/PhD

¿Trabaja como pastor tiempo parcial o tiempo completo? _____

¿Cuántos años ha estado trabajando como pastor? _____

¿Ha sido ordenado? ☐ Sí ☐ No

¿Cuántas iglesias o congregaciones tiene actualmente bajo su cuidado?: _____

¿Cuántos años ha servido en la iglesia o distrito actual? _____

¿Qué categoría describe mejor su distrito o iglesia? ☐ Urbano ☐ Suburbano ☐ Rural

¿Cuántos años sirvió en su última iglesia o distrito? _____

¿Cuántos años ha estado casado/a? _____

¿Cuántos hijos tiene? _____ ¿Qué edades tienen sus hijos? _____

Si se sintiese desanimado/a y necesitase algún consejo, ¿a quién recurriría? (Marque todos los que apliquen):

☐ Su esposo/a

☐ Un amigo cercano/no miembro de mi congregación

☐ Otro miembro de su familia

☐ Un amigo cercano/miembro de mi congregación

☐ Un colega pastor

☐ Presidente de la conferencia

☐ Un consejero profesional

☐ Secretario ministerial

☐ Otro / Explique: _____

Para nuestra familia, lo más difícil de estar en el ministerio es _____

¿Cuál es la ventaja o bendición más grande de estar en el ministerio? (Mencione sólo una, por favor) _____

¡MUCHAS GRACIAS POR TOMAR EL TIEMPO PARA AYUDARNOS CON ESTE ESTUDIO!

La información que nos dio nos beneficiará a todos ayudándonos a entender mejor este tema tan importante.

QUESTIONNAIRE FOR PASTORS

I. Honestly evaluate whether you have far too little, too little, just right, too much, or far too much of these elements in your life: Just **circle** a rating on the 1 to 6 scale for each area.

		FAR TOO LITTLE		JUST RIGHT	FAR TOO MUCH		DOESN'T APPLY
1.	* The amount of physical exercise that I get	1	2	3	4	5	6
2.	* Professional growth	1	2	3	4	5	6
3.	* Friendship	1	2	3	4	5	6
4.	* Quality time spent with my spouse	1	2	3	4	5	6
5.	* Vacation and leave time	1	2	3	4	5	6
6.	* Financial Resources	1	2	3	4	5	6
7.	* Quality time spent with my children and/or extended family	1	2	3	4	5	6
8.	* Intimacy / Sexual life	1	2	3	4	5	6
9.	* Prayer and meditation	1	2	3	4	5	6

II. How satisfied are you with the following aspects of your life? **Circle** a rating on the 1 to 6 scale expressing if you are very happy, happy, satisfied, unhappy or very unhappy.

		VERY HAPPY		SATISFIED	VERY UNHAPPY		DOESN'T APPLY
10.	* The time I spend in recreation and enjoyable activities	1	2	3	4	5	6
11.	* My relationship with my superiors	1	2	3	4	5	6
12.	* The opportunities for educational growth provided by my conference	1	2	3	4	5	6
13.	* Communication with my spouse	1	2	3	4	5	6
14.	* My salary	1	2	3	4	5	6
15.	* The congregation's appreciation of my work	1	2	3	4	5	6
16.	* The time I devote to nourishing my own spiritual life	1	2	3	4	5	6
17.	* The social support from friends and family	1	2	3	4	5	6
18.	* My spouse's trust and respect for me	1	2	3	4	5	6
19.	* The level of education I was able to achieve	1	2	3	4	5	6
20.	* How I treat my spouse	1	2	3	4	5	6
21.	* My spouse working outside the home	1	2	3	4	5	6
22.	* The overall spirituality of our family	1	2	3	4	5	6

QUESTIONNAIRE FOR PASTORS

III. How strongly do you agree or disagree with the following statements? Circle a rating on the 1 to 6 scale expressing whether you strongly agree, agree, don't know, disagree, or strongly disagree.

		STRONGLY AGREE	DON'T KNOW	STRONGLY DISAGREE	DOESN'T APPLY		
23.	* My superiors are pleased with my work.	1	2	3	4	5	6
24.	* My wife is happy working outside the home.	1	2	3	4	5	6
25.	* I would be reluctant to share my problems with others for fear that private issue may become public.	1	2	3	4	5	6
26.	* I eat a balanced diet.	1	2	3	4	5	6
27.	* The ministry creates much stress for my family.	1	2	3	4	5	6
28.	* I have seriously considered leaving the ministry.	1	2	3	4	5	6
29.	* I would see a professional counselor if I needed one.	1	2	3	4	5	6
30.	* I am contented with my marriage.	1	2	3	4	5	6
31.	* I often feel lonely.	1	2	3	4	5	6
32.	* I am happy in my ministry.	1	2	3	4	5	6
33.	* My wife feels she is fulfilling the congregation's expectations.	1	2	3	4	5	6
34.	* I feel confident to go to my conference administration for support in sensitive personal problems.	1	2	3	4	5	6
35.	* The problems and conflict in my church/es affect me personally.	1	2	3	4	5	6
36.	* My wife supports my ministry.	1	2	3	4	5	6
37.	* I believe I should seek advise only from God when I am going through personal problems.	1	2	3	4	5	6
38.	* I need to learn to manage my time better.	1	2	3	4	5	6
39.	* I have fellow pastors with whom I feel free to share sensitive personal problems.	1	2	3	4	5	6
40.	* There is a sense of competition among the pastors in my conference.	1	2	3	4	5	6
41.	* I fear my reputation and my job might be at stake if I share my problems with others.	1	2	3	4	5	6
42.	* I have no one to go to when I feel discouraged and lonely.	1	2	3	4	5	6
43.	* More opportunities to work and fellowship with fellow pastors would benefit my ministry.	1	2	3	4	5	6
44.	* I believe that some extra time off, like a sabbatical, would help me pull myself together.	1	2	3	4	5	6

QUESTIONNAIRE FOR PASTORS

IV. Please, answer the following questions as honestly as possible, by checking the appropriate box.

	YES	NO	DOESN'T APPLY
45. * Do you normally work more than 45 hours per week?	☐	☐	☐
46. * Do you have debts for a total of over \$10,000? (Excluding home mortgage)	☐	☐	☐
47. * Do you think you made the right decision in entering the ministry?	☐	☐	☐
48. * Are you comfortable with the expectations the Adventist church has of you?	☐	☐	☐
49. * Do you sleep a minimum of 7 hours per night?	☐	☐	☐
50. * Do you share with your wife the education and discipline of your children?	☐	☐	☐
51. * Do you generally take your weekly day off to rest and be with your family?	☐	☐	☐
52. * In the last 10 years, have you moved more than 2 times?	☐	☐	☐
53. * Do you go to the doctor for a regular check-up?	☐	☐	☐
54. * Do you have debts for a total of less than \$10,000? (Excluding home mortgage)	☐	☐	☐
55. * Is somebody in your close family (spouse, children) seriously ill?	☐	☐	☐
56. * Does a close relative of yours suffer from depression?	☐	☐	☐
57. * Do you become discouraged rather easily?	☐	☐	☐
58. * Have you ever attempted suicide?	☐	☐	☐
59. * Do you think you are experiencing some degree of depression right now?	☐	☐	☐
60. * If yes, can you pinpoint the main reason/s? (Check as many as may apply)			
☐ Family issues			
☐ Health problems			
☐ Work related issues			
☐ Financial problems			
☐ Other / Please explain: _____			
61. * Have you experienced depression in the past?	☐	☐	☐
62. * If yes, can you pinpoint the main reason/s? (Check as many as may apply)			
☐ Family issues			
☐ Health problems			
☐ Work related issues			
☐ Financial problems			
☐ Other / Please explain: _____			
63. * What helped you to overcome your depression in the past? (Check as many as may apply)			
☐ Medical treatment			
☐ Better health habits			
☐ The support of your family			
☐ Counseling			
☐ The support of your friends			
☐ A stronger devotional life			
☐ Taking care of unsolved issues of the past			
☐ Other / Please explain: _____			
64. * Have you experienced any of the following over the last 12 months?			
☐ Death of spouse			
☐ Divorce/marital separation			
☐ Death of close family member			
☐ Serious injury or illness of a close family member			
☐ Marriage			
☐ Geographical relocation			
☐ Personal injury or illness			

QUESTIONNAIRE FOR PASTORS

The following questions will help us understand how different groups of ministers view things. You can complete them with the assurance that this information, as well as your identity—if you chose to share it with us—will be kept under the strictest reserve, and will only be handled by the doctoral student, and his adviser. The seriousness and sensibility of this study demands that we handle the information you will kindly provide us with the highest degree of confidentiality.

Name: _____
(Optional - only if you want the results of the Zung Confidential Assessment Test)

Age: _____

Place of birth:

☐ Caribbean Islands	☐ Mexico
☐ South America	☐ Spain
☐ Interamerica (excluding Mexico)	☐ Other: _____

Highest educational degree earned or in process:

- ☐ BA in Theology ☐ Master degree ☐ M.Div ☐ D.Min ☐ EdD/PhD

Do you work as a pastor full-time, or part-time? _____

How many years have you been employed as a minister? _____

Are you ordained? ☐ Yes ☐ No

How many churches or congregations are under your care currently?: _____

How many years have you served at your present church/es? _____

Which of the following best describes your present church/es? ☐ Urban ☐ Suburban ☐ Rural

How many years did you serve in your last church/es? _____

How long have you been married? _____

How many children do you have? _____ How old are they? _____

65. If you felt discouraged, and you needed to seek council, who would you see (mark all that may apply)
☐ Your spouse	☐ A close friend/not a church member from your congregation
☐ Other family member/s	☐ A close friend/a church member from your congregation
☐ A fellow minister	☐ Conference president
☐ A professional counselor	☐ Ministerial secretary
☐ Other / Explain: _____	
66. For our family, the most difficult thing about being in the ministry is _____
67. What is the single greatest advantage of your being in the ministry? _____

THANK YOU FOR TAKING THE TIME TO HELP US WITH THIS!

The information you gave us will benefit all of us helping us to understand better this important issue

SURVEY ON SUPPORT RESOURCES AVAILABLE TO MINISTERS
AT THE CONFERENCE LEVEL

Does your conference carry out or support any of the following programs?

I. Professional Growth

*Periodical ministerial meetings

**Ministerial Training/Seminars ☐ Yes ☐ No

Frequency ☐ Once a year ☐ Every other year ☐ Other, explain _____

**Regional/ethnic group meetings ☐ Yes ☐ No

Frequency ☐ Once a year ☐ Every other year ☐ Other, explain _____

**Others, please explain _____

*Mentor/senior program for interns (new pastors) ☐ Yes ☐ No

*Pastoral team projects ☐ Yes ☐ No

*Consultation program availability

(with ministers specialized in different areas) ☐ Yes ☐ No

*Pastoral support (ministerial director and/or other) including visitation, counseling

Frequency ☐ Once a year ☐ Twice a year ☐ Other, explain _____

*Systematic continuous education program ☐ Yes ☐ No

Frequency ☐ Once a year ☐ Every other year ☐ Other, explain _____

Please, explain how this is organized in your conference _____

*Supply of professional aid materials

(books, magazines, tapes, videos, etc.) ☐ Yes ☐ No

*Subsidized opportunities to further education

**MDiv ☐ Yes ☐ No

**DMin ☐ Yes ☐ No

*Sabbatical period (with pay) ☐ Yes ☐ No

If yes, with what purpose/s?

☐ Educational ☐ Health reasons ☐ Renewal period

And for how long?

☐ Three months ☐ Six months ☐ Other, explain _____

*Others, please explain: _____

II. Family/Social Support

*Ministerial families retreats ☐ Yes ☐ No

Frequency ☐ Once a year ☐ Every other year ☐ Other, explain _____

*Ministerial Social events (dinners, etc.) ☐ Yes ☐ No

Frequency ☐ Once a year ☐ Every other year ☐ Other, explain _____

*Others, please explain: _____

Continues at the back ⇌

III. Other Mental Health Resources (when needed)

*Marital counseling	☐ Yes	☐ No
*Independent pastoral counseling	☐ Yes	☐ No
*Ministerial support group	☐ Yes	☐ No
*Therapy counseling	☐ Yes	☐ No
*Depression Treatment	☐ Yes	☐ No

*Others, please explain: _____

*In case any of the previous resources are needed does the insurance/conference pay for the cost? Please explain _____

*Are workers aware of what resources are available to them? _____

*Are they encouraged to use them? _____

*Confidentiality issues in case of special counseling/ treatment:

Do workers deal with independent institutions/agencies/professionals? _____

Must the ministers or agencies involved report to the conference office? _____

Additional Comments:

Please, mail this form by April 10 to:
 Elder Enrique N. Calandra
 550 Maplewood Ct. C-67
 Berrien Springs, MI 49103

APPENDIX C

ADDITIONAL TABLES

- **Tables 36-40. Chi-Square Tests of SDS Scores and Demographic Data in Categories**
- **Table 41. Spearman Correlations of SDS Scores and Continuous Demographic Data**
- **Table 42. Spearman Correlations of SDS Scores and the Answers to the Questionnaire for Pastors**

Table 36. Chi-Square Test of SDS Scores and Place of Birth of the Respondents
(Percentages of Total Population and *N* Given in Parenthesis)

SDS CLINICAL GLOBAL IMPRESSIONS	PLACE OF BIRTH						TOTALS
	MEXICO	INTERAMERICA	CARIBBEAN	S. AMERICA	U.S.A.	OTHERS	
Normal	15.8 (35)	14.0 (31)	18.9 (42)	19.4 (43)	7.5 (17)	0.5 (1)	76.1 (169)
Elevated	4.0 (9)	4.9 (11)	5.9 (13)	7.2 (16)	1.9 (4)	0	23.9 (53)
Total Count	19.8 (44)	18.9 (42)	24.8 (55)	26.6 (59)	9.4 (21)	0.5 (1)	100.0 (222)
Pearson Chi-Square Test: Value $\chi^2 = 1.143$; $df = 5$; $p = .887$							

Table 37. Chi-Square Test of SDS Scores and Educational Level of the Respondents
(Percentages of Total Population and *N* Given in Parenthesis)

SDS CLINICAL GLOBAL IMPRESSIONS	EDUCATIONAL LEVEL					TOTALS
	BA IN THEOLOGY	MDIV	OTHER MASTER DEGREE	DMin	EdD/PhD	
Normal	18.5 (41)	16.7 (37)	32.9 (73)	6.3 (14)	1.7 (4)	76.1 (169)
Elevated	7.2 (16)	4.5 (10)	11.2 (25)	0.5 (1)	0.5 (1)	23.9 (53)
Total Count	25.7 (57)	21.2 (47)	44.1 (98)	6.8 (15)	2.2 (5)	100.0 (222)
Pearson Chi-Square Test: Value $\chi^2 = 2.989$; $df = 4$; $p = .393$						

**Table 38. Chi-Square Test of SDS Scores and Employment Basis of the Respondents
(Percentages of Total Population and *N* Given in Parenthesis)**

SDS CLINICAL GLOBAL IMPRESSIONS	EMPLOYMENT BASIS		TOTALS
	FULL TIME	PART TIME	
Normal	65.8 (146)	10.3 (23)	76.1 (169)
Elevated	18.0 (40)	5.9 (13)	23.9 (53)
Total Count	83.8 (186)	16.2 (36)	100.0 (222)
Pearson Chi-Square Test: Value $\chi^2 = 3.540$; $df = 1$; $p = .085$			

**Table 39. Chi-Square Test of SDS Scores and Church Settings of the Respondents
(Percentages of Total Population and *N* Given in Parenthesis)**

SDS CLINICAL GLOBAL IMPRESSIONS	CHURCH SETTINGS			TOTALS
	URBAN	SUBURBAN	RURAL	
Normal	52.2 (116)	18.0 (40)	5.9 (13)	76.1 (169)
Elevated	18.0 (40)	4.1 (9)	1.8 (4)	23.9 (53)
Total Count	70.2 (156)	22.1 (49)	7.7 (17)	100.0 (222)
Pearson Chi-Square Test: Value $\chi^2 = 1.087$; $df = 2$; $p = .581$				

Table 40. Chi-Square Test of SDS Scores and Ordination Status of the Respondents
(Percentages of Total Population and *N* Given in Parenthesis)

SDS CLINICAL GLOBAL IMPRESSIONS	ORDINATION STATUS		TOTALS
	ORDAINED	NOT ORDAINED	
Normal	60.3 (134)	15.8 (35)	76.1 (169)
Elevated	19.4 (43)	4.5 (10)	23.9 (53)
Total Count	79.7 (177)	20.3 (45)	100.0 (222)
Pearson Chi-Square Test: Value $\chi^2 = .085$; $df = 1$; $p = .771$			

Table 41. Spearman Correlations of SDS Scores and Seven Additional Demographic Variables

ADDITIONAL DEMOGRAPHIC VARIABLES	SDS SCORE		
	SPEARMAN CORRELATION	SIG. (2-TAILED) - <i>P</i>	<i>N</i>
Age of respondents	-.014	.838	222
Years in the ministry	-.070	.299	222
Number of churches they serve	.028	.682	222
Years at current church	-.109	.106	222
Years at last church	-.001	.986	222
Years of marriage	-.065	.332	222
Number of children	.001	.991	222

Table 42. Spearman Correlations between SDS Scores and the Answers to the Questionnaire for Pastors

QUESTIONS	SDS SCORE		
	SPEARMAN CORRELATION	SIG. (2-TAILED) - P	N
1 *The amount of physical exercise that I get	-.087	.197	222
2 *Professional growth	-.174	.009*	222
3 *Friendship	-.183	.006*	222
4 *Quality time spent with my spouse	-.133	.052	213
5 *Vacation and leave time	-.051	.448	222
6 *Financial resources	-.031	.647	222
7 *Quality time spent with my children and/or extended family	-.105	.130	210
8 *Intimacy / Sexual life	-.066	.337	213
9 *Prayer and meditation	-.032	.640	222
10 * The time I spend in recreation and enjoyable activities	.138	.040*	222
11 * My relationship with my superiors	.212	.001*	222
12 * The opportunities for educational growth provided by my conference	.186	.005*	221
13 * Communication with my spouse	.052	.451	213
14 * My salary	.135	.045*	222
15 * The congregation's appreciation of my work	.224	.001*	222
16 * The time I devote to nourishing my own spiritual life	.053	.432	222

Table 42—*Continued.*

QUESTIONS	
17	* The social support from friends and family
18	* My spouse's trust and respect for me
19	* The level of education I was able to achieve
20	* How I treat my spouse
21	* My spouse working outside the home
22	* The overall spirituality of our family
23	* My superiors are pleased with my work.
24	* My wife is happy working outside the home.
25	* I would be reluctant to share my problems with others for fear that private issues may become public.
26	* I eat a balanced diet.
27	* The ministry creates much stress for my family.
28	* I have seriously considered leaving the ministry.
29	* I would see a professional counselor if I needed one.
30	* I am contented with my marriage.
31	* I often feel lonely.
32	* I am happy in my ministry.
33	* My wife feels she is fulfilling the congregation's expectations.

SDS SCORE		
SPEARMAN CORRELATION	SIG. (2-TAILED) - <i>P</i>	<i>N</i>
.068	.310	222
.015	.829	213
.130	.054*	222
.167	.015*	213
.097	.268	131
.049	.473	217
.310	.000*	222
.038	.660	138
-.221	.001*	222
.231	.001*	222
-.185	.007*	214
-.166	.013*	222
.005	.940	222
.267	.000*	214
-.393	.000*	222
.184	.006*	222
.037	.593	213

Table 42—*Continued.*

QUESTIONS	
34	* I feel confident to go to my conference administration for support in sensitive personal problems.
35	* The problems and conflict in my church/es affect me personally.
36	* My wife supports my ministry.
37	* I believe I should seek advice only from God when I am going through personal problems.
38	* I need to learn to manage my time better.
39	* I have fellow pastors with whom I feel free to share sensitive personal problems.
40	* There is a sense of competition among the pastors in my conference.
41	* I fear my reputation and my job might be at stake if I share my problems with others.
42	* I have no one to go to when I feel discouraged and lonely.
43	* More opportunities to work and fellowship with fellow pastors would benefit my ministry.
44	* I believe that some extra time off, like a sabbatical, would help me pull myself together.
45	* Do you normally work more than 45 hours per week?
46	* Do you have debts for a total of over \$10,000? (Excluding home mortgage)

SDS SCORE		
SPEARMAN CORRELATION	SIG. (2-TAILED) - <i>P</i>	<i>N</i>
.133	.049*	222
-.143	.033*	222
.107	.121	213
-.209	.002*	222
-.131	.052	222
.075	.267	222
-.162	.016*	222
-.229	.001*	222
-.273	.000*	221
-.083	.217	222
-.129	.055	222
.004	.957	222
.012	.860	222

Table 42—*Continued.*

QUESTIONS		SDS SCORE		
		SPEARMAN CORRELATION	SIG. (2-TAILED) - <i>P</i>	<i>N</i>
47	* Do you think you made the right decision in entering the ministry?	-.008	.906	222
48	* Are you comfortable with the expectations the Adventist church has of you?	.208	.002*	222
49	* Do you sleep a minimum of 7 hours per night?	.148	.028*	222
50	* Do you share with your wife the education and discipline of your children?	.212	.004*	182
51	* Do you generally take your weekly day off to rest and be with your family?	.231	.001*	222
52	* In the last 10 years, have you moved more than 2 times?	.053	.435	222
53	* Do you go to the doctor for a regular check-up?	.089	.189	222
54	* Do you have debts for a total of less than \$10,000? (Excluding home mortgage)	-.142	.035*	222
55	* Is somebody in your close family (spouse, children) seriously ill?	-.025	.714	222
56	* Does a close relative of yours suffer from depression?	-.123	.069	221
57	* Do you become discouraged rather easily?	-.309	.000*	222
58	* Have you ever attempted suicide?	-.005	.940	222
59	* Do you think you are experiencing some degree of depression right now?	-.381	.000*	222

Note: Statistically significant correlations at $p = 0.05$ have an "*" sign next to the p value)

APPENDIX D

ADDITIONAL RESOURCES

- **Support Resources Available to Ministers at the Conference Level**
- **Informational and Support Resources**

SUPPORT RESOURCES AVAILABLE TO MINISTERS AT THE CONFERENCE LEVEL

This survey was sent to the 48 conferences that conform the territory of the North American Division of the Seventh-day Adventists. Of these, 25 responded, and their answers are organized in alphabetical order:

Tables 43 and 44 present partial results of the resources available in these territories. A couple of services—ministerial training seminars and pastoral support—are provided by all of these conferences. Other services vary a lot: some of them are provided by most of the conferences and others by very few. Since the tables are self explanatory, I would just like to add some additional details on these and other resources provided by the conferences.

The frequency of ministerial training sessions or seminars varies from every other year to four times a year, with most conferences doing it once a year. Regional and ethnic group meetings are held anywhere from every month to once a year.

Mountain View Conference is just beginning to implement a mentoring program for interns and the Pennsylvania Conference holds a *New in Ministry Retreat* with seminars once a year. The Hispanic Coordinator functions as consultant/evangelist for Hispanic pastors in several territories, reportedly adding to the effectiveness of these ministers.

I was astonished to find out that not all conferences offer systematic continuous education programs. Among those who offer them, the way they are organized or their frequency varies greatly, from conferences which organize seminars/classes at their location twice a year, once a year, or every other year, to conferences that give each pastor money to spend in professional enrichment. This allowance varies from \$100 to \$600 a year depending on the conference.

Sabbatical periods are granted anywhere from one week to three months for educational purposes, health reasons, and as periods of renewal. I am not sure if such a short period as one or two weeks would qualify to be considered "sabbatical periods," though. Some conferences request a written report of the project worked at during the sabbatical at the end of the period. Michigan Conference grants up to \$1,000 for projects, in addition to the continuation of salary.

Southern California conference requires a M.A. in Religion or a M.Div. for ordination, and they subsidize education costs to attain these degrees. When approved by their conference and union, they will cover up to two thirds of the costs of the D.Min. program as well. Several other conferences subsidize M.Div. and/or D.Min studies.

Table 43. Support Resources Available to SDS Ministers at the Local Conference Level
(Conferences 1-13)

SUPPORT RESOURCES	CONFERENCES BY GIVEN NUMBERS												
	1	2	3	4	5	6	7	8	9	10	11	12	13
<u>Professional Growth</u>													
Periodical ministerial meetings													
* Ministerial Training/Seminars	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
* Regional/ethnic group meetings	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓
* Others													
Mentor/senior pastor program for interns	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pastoral team projects	✓		✓	✓	✓			✓		✓	✓		✓
Consultation program (with ministers specialized in different areas)				✓		✓		✓		✓	✓		
Pastoral support, including visitation and counseling (Ministerial director and/or other)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Systematic continuous education program	✓		✓	✓		✓	✓	✓		✓	✓	✓	✓
Supply of professional aid materials (books, magazines, tapes, videos, etc.)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Subsidized opportunities for further education													
*M.Div.		✓	✓	✓						✓	✓	✓	✓
*D.Min.		✓	✓	✓	✓		✓	✓		✓	✓	✓	

Table 43—*Continued.*

SUPPORT RESOURCES	CONFERENCES BY GIVEN NUMBERS												
	1	2	3	4	5	6	7	8	9	10	11	12	13
<u>Professional Growth (Cont.)</u>													
Sabbatical period (with pay)	✓	✓	✓		✓					✓			
Others	✓									✓			
<u>Family/Social Support</u>													
Ministerial families retreats	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Ministerial social events (Dinners, etc.)	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Others	✓									✓			
<u>Additional Professional Resources</u>													
Marital counseling	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓
Independent pastoral counseling	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓
Ministerial support group	✓			✓	✓	✓		✓		✓	✓	✓	
Therapy counseling	✓	✓		✓	✓	✓				✓	✓		✓
Depression Treatment	✓	✓		✓	✓	✓				✓	✓		✓

Table 43—*Continued.*

SUPPORT RESOURCES	CONFERENCES BY GIVEN NUMBERS												
	1	2	3	4	5	6	7	8	9	10	11	12	13
<u>Additional Professional Resources (Cont.)</u>													
Does insurance pay for the cost of these services?	✓	✓		✓	✓	✓		✓		✓	✓	✓	✓
Are workers aware of the resources available?	✓	✓		✓	✓	✓		✓	✓	✓	✓		✓
Are they encouraged to use them?	✓	✓		✓	✓	✓		✓	✓	✓	✓		✓
Is the conference taking measures to ensure that confidentiality issues are properly cared for?		✓		✓	✓	✓			✓	✓	✓		✓

Note: 1 = Alberta Conference, Canada; 2 = Carolina Conference; 3 = Central States Conference; 4 = Gulf States Conference; 5 = Illinois Conference; 6 = Indiana Conference; 7 = Kentucky-Tennessee Conference; 8 = Lake Region Conference; 9 = Manitoba-Saskatchewan Conference, Canada; 10 = Michigan Conference; 11 = Mountain View Conference; 12 = Nevada-Utah Conference; 13 = New York Conference.

Table 44. Support Resources Available to SDS Ministers at the Local Conference Level
(Conferences 14-25)

SUPPORT RESOURCES	CONFERENCES BY GIVEN NUMBER											
	14	15	16	17	18	19	20	21	22	23	24	25
<u>Professional Growth</u>												
Periodical ministerial meetings												
* Ministerial Training/Seminars	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
* Regional/ethnic group meetings	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓
* Others												
Mentor/senior pastor program for interns	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓
Pastoral team projects	✓	✓	✓			✓					✓	✓
Consultation program (with ministers specialized in different areas)	✓	✓									✓	✓
Pastoral support, including visitation and counseling (Ministerial director and/or other)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Systematic continuous education program	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓
Supply of professional aid materials (books, magazines, tapes, videos, etc.)	✓	✓				✓	✓	✓	✓	✓	✓	✓
Subsidized opportunities for further education												
*M.Div.	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
*D.Min.	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓

Table 44—*Continued.*

CONFERENCES BY GIVEN NUMBERS												
CONFERENCES BY GIVEN NUMBERS	14	15	16	17	18	19	20	21	22	23	24	25
<u>Professional Growth (Cont.)</u>												
Sabbatical period (with pay)		✓						✓	✓	✓		
Others									✓			
<u>Family/Social Support</u>												
Ministerial families retreats	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓
Ministerial social events (Dinners, etc.)	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓
Others	✓						✓				✓	✓
<u>Additional Professional Resources</u>												
Marital counseling	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Independent pastoral counseling	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Ministerial support group	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓
Therapy counseling	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Depression Treatment	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓

Table 44—*Continued.*

SUPPORT RESOURCES	CONFERENCES BY GIVEN NUMBERS											
	14	15	16	17	18	19	20	21	22	23	24	25
<u>Additional Professional Resources</u> (Cont.)												
Does insurance pay for the cost of these services?	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Are workers aware of the resources available?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Are they encouraged to use them?	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Is the conference taking measures to ensure that confidentiality issues are properly cared for?	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓

Note: 14 = Northern California; 15 = Ohio Conference; 16 = Oklahoma Conference; 17 = Ontario Conference, Canada; 18 = Oregon Conference; 19 = Pennsylvania Conference; 20 = Southern California Conference; 21 = Southeastern California Conference; 22 = Southern New England Conference; 23 = Texas Conference; 24 = Upper Columbia Conference; 25 = Washington Conference.

In addition to ministerial families retreats and social events—which most conferences hold once or twice a year—a few conferences have regional/ethnic pastors meals, and or other social/family activities. Michigan Conference gives each family \$100 to use for social events as they desire and they also have a retreat lodge at Camp Au Sable to be used exclusively by ministers and their families.

As for counseling resources, a number of conferences use the Ministry Care Line (1-800 hot line provided by Kettering Hospital or Harding Hospital) which gives confidential counseling and sends blind billings to the conferences. Some conferences have made special arrangements with independent agencies or professionals for counseling and treatments, also ensuring that blind billing is sent to the conference Treasury Department.

Pennsylvania Conference bought and made available to pastors wives several copies of the book *I Have to Be Perfect and Other Parsonage Heresies*, and also brought an outside counselor for pastors meetings. This counselor did several presentations and offered private sessions to all those who wanted, covered by the conference. The conference reported this was very well received.

Upper Columbia Conference has a certified counselor available to their pastors and teachers. He is also establishing support groups where there is interest, and works on a rotating basis often visiting pastors' homes. He offers testing, and is always available at pastors and teachers meetings. The counselor's services are also available to the Upper Columbia church members. All of this is done under strict confidentiality guidelines. The conference reports that "this has been a tremendous blessing to our pastors."

A few conferences still need to work on confidentiality issues: they limit the number of counseling sessions that can be done anonymously, and request, for instance that after the first three to six sessions, the administration be notified about it. This very probably discourages ministers from making use of these resources!

In general, the conferences that answered this survey expressed a positive disposition to help its ministers as much as possible. They shared how they are trying new things, and how sometimes the budget prevents them from providing other resources. But we can not disregard the fact that only 52 % of the North American Division local conferences answered this survey. It would be very interesting to have a more complete picture by hearing what the other 48% does.

Furthermore, it may be highly positive if several of these resources could be included in the NAD working policy so as to ensure that they are available to all ministers in the territory of the North American Division.

INFORMATIONAL AND SUPPORT RESOURCES

The Alban Institute, Inc. (800) 486-1318
7315 Wisconsin Ave., Ste. 1250 W, Bethesda, MD 20814

* Helpful publications , workshops, and periodical *Action Information*

American Association of Pastoral Counselors
9504 A Lee Highway, Fairfax, VA 22031-2303 (703) 385-6967
<http://www.aapc.org/>

Care Line
Kettering Clergy Care Center
3535 Southern Blvd., Kettering, OH 45429 (937) 298-4331

Christian Association for Psychological Studies
University Hills Christian Center, 27000 Farmington Rd.
Farmington Hills, MI 48018

Christian Medical Society
1122 Westgate, Oak Park, IL 60301

* These two national Christian organizations publish membership directories of mental-health professionals in various fields.

Christian Schools of Psychology:

Fuller Theological Seminary Graduate School of Psychology (626) 584-5200
177 North Madison Ave., Pasadena, CA 91101

Rosemead Graduate School of Professional Psychology (562) 903-6000
Biola University, 13800 Biola Ave., La Mirada, CA 90638

* These schools keep a national register of practicing Christian psychologists.

International Association of Counseling Services, Inc. (703) 823-9840
Two Skyline Pl. Suite 400, 5203 Leesburg Pike
Falls Church, VA 22041

- * A Directory of Counseling Services, including accredited pastoral counseling centers.

National Foundation for Depressive Illness 1-800-248-4344

- * Has recorded information on depression. You'll also receive direction for how to obtain further information and a list of health care providers in your area who know about depression.

National Mental Health Association 1-800-969-6642

- * Call for free information on many mental health topics, or to receive a national directory of local mental health associations.

National Institute of Mental Health's Depression
and Panic Disorder Hotline 1-800-421-4211

- * Call for free brochures, including material in Spanish.

National Alliance for the Mentally Ill 1-800-950-6264

National Depressive and Manic-depressive Association 1-800-826-3632

Society for the Advancement of Continuing Education for Ministry
3401 Brook Rd.
Richmond, Virginia 23227

- * Information on continuing education programs available.

Suicide Crisis Centers (in different states) See <http://www.cyberpsych.org/ass/aascris.htm>

For additional resources in your area, look in the front of your phone book or in the Yellow Pages under "Mental Health."

APPENDIX E

**SERIES OF ARTICLES PREPARED
TO BE PUBLISHED IN *MINISTRY***

A Study on Depressive Symptomatology among Hispanic Ministers
of the North American Division of Seventh-day Adventists
Part I

The intensity of our modern work and living has led to a dramatic increase in the incidence and severity of stress-related disorders, including depression. Ministers—as human beings and helping professionals—are not exempt from these realities. In fact, several studies have shown that they are especially vulnerable to them.¹ Their roles and job descriptions put them in many very demanding situations.

A placard once used in recruiting priests read: “The great moments in a person’s life are: Birth, Confirmation, Communion, Marriage, and Death. Would you like to be the person most needed at such times?”² And even though these crucial moments in a person’s life require special skills and great understanding, they are not the only events that emotionally exhaust the ministers.

In fact, ministers are expected to have outstanding talents in every field of knowledge. They are expected to fulfill everybody’s expectations and work tirelessly fourteen hours a day and seven days a week. They are also expected to maintain an irreproachable behavior, to have a perfect family, and to be all-wise and ever-present. “Ministers are placed upon a pedestal—a position that allows little room for human weaknesses.”³

The truth is, though, that pastors are not superhuman! Many of the problems pastors experience arise when they forget they are normal human being, struggling with the same issues than everyone else in addition to the specific problems related to their ministerial profession. Overwork, feelings of failure, physical or emotional pain, grief, and loneliness may lead pastors to experience shorter or longer periods of depression. Oftentimes, feelings of guilt, mistrust, fear of jeopardizing their jobs, or low self-esteem can worsen their depression, leading them to overwhelming anxiety and, in some extreme cases, even intents of suicide.

What is Depression?

Depression is a word with many meanings. Most people use the term to refer to feelings of sadness, or a temporary mood resulting from a loss, disappointment, or failure. But in the *psychiatric* sense, “depression is much more than a feeling of sadness. It is a serious medical condition, which adversely affects not only a person’s feelings but also his or her health, productivity, relationships, and ability to think clearly and rationally.”⁴ It is a medical disorder as real and as serious as diabetes or cancer, and it affects the body as well as the mind, trapping its victims in a state of hopelessness and helplessness.

In fact, it is one of the oldest human afflictions of which we have written records. Hippocrates, the ancient Greek healer who lived in the fifth century B.C., Plutarch, in the second century A.D., and William Shakespeare—among many others—referred to this illness and its symptoms. They used to call it “melancholia.”

According to conservative estimations, depression affects more than 17 million Americans each year.⁵ “It is the second leading cause of lost days at work, and a study found that it costs employers about \$33 billion a year in absenteeism and lost productivity.”⁶ Moreover, the median age for depression, and for its most drastic consequence—suicide—has fallen during this century from between forty and fifty to just under thirty.⁷ However, a remarkable fact is that fewer than one-third of these millions ever receive treatment or are aware that their misery could be relieved.⁸ Over a course of a lifetime, up to 12 percent of men and 20 percent of women will suffer from *depressive illness*. Its episodes can last from a few months to many years, and if not properly treated, it is highly recurrent: 80 percent of patients who have had a depressive episode will have another one.⁹

Depression in the Bible

Although the word depression does not appear in the Bible, clear descriptions of depressive symptoms can be found in several of its books. Terms such as: despair, cast down, and sad may refer to forms or symptoms of depressive illness. There are references to several Biblical characters suffering from depression: Moses (Num 11:15), Elijah (1 Kgs 19:4), and Job (Job 3:1-21). In fact, Job’s experience exemplifies a typical case of depression resulting from losses; and yet, in looking at Job, God exclaimed “there is no one like him, . . . a blameless and upright man, fearing God and turning away from evil” (Job 1:8).

Additional references to depressive symptoms can be found in Hannah (1 Sam 1:7), Jonah (Jonah 4:1-3), and Jeremiah (Lam 1-5). In the Psalms, David opens his heart to God giving us a clear picture of the depressive episodes which tormented him (Pss 6:6-7; 40:12; 69; 88; and 102).

Jesus himself, while praying in the Garden of Gethsemane, was greatly distressed. The Amplified Bible says: “He began to show grief and distress of mind and was deeply depressed. Then He said to them, My soul is very sad and deeply grieved, so that I am almost dying of sorrow (Matt 26:37-38).” Writing about this experience, Ellen G. White tells about the angel sent from Heaven to strengthen Jesus to drink the cup of suffering, and explains: “Christ’s agony did not cease, but his depression and discouragement left him. He still carried the load of guilt, and he fulfilled the demands of the divine law, and glorified the Father by drinking the bitter cup.”¹⁰

These incidents are consistent with the realism that characterizes the Bible and show that depression has always been a part of human experience. Nevertheless, “each of the believers who plunged into depression eventually came through and experienced a new and lasting joy. The biblical emphasis is less on human despair and more on belief in God and the assurance of abundant life in heaven, if not on earth.”¹¹

Ellen G. White's Comments on Depression

Sister White wrote extensively on the topic of depression. There are seventy three references to the expressions "depression" among her published works. Her testimonies include letters to people suffering from depression, and she acknowledges that both she and her husband suffered from depression at different times of their lives. In fact, James White suffered from frequent depression episodes, and disclosing one of her own experiences she wrote,

For some months past my spirit has been much depressed. God has seen fit to use me, a feeble instrument, for a few years past by giving me visions. This place I have not desired. I have ever known that it would cause me many hours of anguish of spirit. . . . My feelings have been sensitive, and while with the fear of God before me, I have been obliged to faithfully relate what God has shown me, my sufferings of mind have been intense.¹²

Even in the midst of these difficult periods, though, she strived to have a positive attitude, and frequently encouraged others to do the same. All her quotations dealing with depression reflect her deep empathy, tender care, and insightful understanding of its symptoms, causes, and effects. Her writings are filled with words of encouragement, and reminders of God's promises of strength and support.

Depression among Ministers

An article published in *Christianity Today* begins by stating, "If you're a discouraged pastor, you're in good company—the company of Luther, Calvin, Bonar, Morgan, and Spurgeon."¹³ Indeed, Martin Luther, in spite of playing a key role in the Reformation and writing hymns such as "A Mighty Fortress Is Our God," suffered from chronic depression,¹⁴ and Charles Spurgeon, one of the greatest preachers of all time, who drew thousands to his London church and influenced ministers all over the world with his faithful commitment to Christ, lived with great emotional problems.

'From boyhood days dreadful moods of depression repeatedly tormented him,' one biographer wrote. His despondency forced him to be absent from his pulpit two to three months out of the year. In 1866 he openly shared his struggles with his congregation: 'I am the subject of depressions of spirit so fearful that I hope none of you ever get to such extremes of wretchedness as I go [through].' During these depression, he said, 'Every mental and spiritual labor. . . had to be carried on under protest of spirit.'¹⁵

In the last two decades several clergy people disclosed their experiences with depression in published books.¹⁶ By sharing their personal experiences, these ministers warn us of the dangers and give us valuable insights on how they were able not only to overcome depression, but even grow through their experience.

We need to be aware that, in spite of the joyous experience of soul-winning and of nurturing and building God's church, depression is a major occupational hazard for ministers but because there is still a "stigma" connected to mental illnesses, this issue is seldom discussed.

It is time we challenged the stupidity of this stigma. Perhaps if we called depression a brain disease, which in many respects it is, that would move it more toward the physical and hence make it more acceptable. Because of the stigma, families have often tended to cover up for their depressed member—to "hide" him or her. Therefore the depressed person doesn't get to the needed help as soon as possible. The condition, consequently, grows worse.¹⁷

Although this is a sensitive issue, it needs to be discussed more openly, acknowledging its existence and taking steps to find causes and solutions. As ministers, we may find it harder than others to admit our weaknesses, but "just as the first step to spiritual healing involves recognizing we are sinners, the first step to emotional healing involves recognizing we have emotional weaknesses."¹⁸

I would be unfair if I did not mention as well the greatly rewarding experiences most ministers enjoy. For most ministers the spiritual rewards of Christian service are so satisfying that they outweigh by far the loneliness, despair, and stress they frequently undergo. Nevertheless, "too many pastors never achieve this level of satisfaction, and we need to be honest enough in our evaluation to confront the real reasons for this."¹⁹

These realities challenged me to conduct a research on depressive symptomatology among Hispanic Ministers of the North American Division as part of my doctoral dissertation. The results of this study will be presented in the next article on this series.

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1. Archibald D. Hart, *Coping with Depression in the Ministry and Other Helping Professions* (Waco, TX: Word, 1984), 12.
 2. Quoted by G. Curtis Jones, *The Naked Shepherd* (Waco, TX: Word, 1979), 75.
 3. Benjamin D. Schoun, "The Minister as a Human Being" in C. Raymond Holmes and Douglas Kilcher, eds, *The Adventist Minister* (Berrien Springs, MI: Andrews University Press, 1991), 2.
 4. Brian P. Quinn, *The Depression Sourcebook* (Los Angeles, CA: Lowell House, 1997), vii.
 5. National Institutes of Health's Guide for Students, "What to Do If a Friend Has Depression"; <available from <http://www.save.org/student.html>>; November 96; accessed October 7, 1997, 1-4.
 6. Quinn, viii.
 7. Hart, 4-5.
 8. Peter C. Whybrow, *A Mood Apart—Depression, Mania, and Other Afflictions of the Self* (New York, NY: Basic Books, 1997), 7.

9. Quinn, vii.
10. Ellen G. White, "Gethsemane," *The Signs of the Times*, June 3, 1897, 1.
11. Gary R. Collins, *Christian Counseling* (Dallas, TX: Word, 1988), 106.
12. Ellen G. White, "Communication from Sister White," *Second Advent Review and Sabbath Herald*, January 10, 1856, 1.
13. Andre Bustanoby, "How to Cope with Discouragement," *Christianity Today*, January 7, 1997, 3.
14. Dwight L. Carlson, *Why Do Christians Shoot Their Wounded?* (Downers Grove, IL: InterVarsity, 1994), 38-40.
15. Ibid.
16. A couple of examples are: C. Welton Gaddy, *A Soul under Siege: Surviving Clergy Depression* (Philadelphia, PA: Westminster, 1991); and Jim Conway, *Men in Mid-Life Crisis* (Elgin, IL: David C. Cook, 1978), 11, 12.
17. William Hulme and Lucy Hulme, *Wrestling with Depression* (Minneapolis, MN: Augsburg, 1995), 109.
18. Carlson, 137.
19. Hart, 13.

A Study on Depressive Symptomatology among Hispanic Ministers
of the North American Division of Seventh-day Adventists
Part II

In spite of the joyous experience of soul-winning and of nurturing and building God's church, depression is a major occupational hazard for ministers. This reality challenged me to study this matter further, searching relevant data on the existence of depressive symptomatology among the Hispanic ministers of the North American Division of Seventh-day Adventists.

Why this group specifically? First, because as a Hispanic minister, it is a population I know and understand better; and second, because some of the cultural characteristics of Hispanics may cause this ethnic group to be more vulnerable to depression than others.

Hispanics in the United States

The term "Hispanic" here is used to indicate individuals whose common background is the Spanish language. Although Hispanics share common characteristics, to better understand this very heterogeneous group we must keep in mind that there are distinct differences between and within the different groups and/or countries Hispanics represent; so we need to be careful not to misuse information making generalizations in a stereotypical fashion.

Hispanics comprised a population of 28.3 million in 1996.¹ Some of the issues, traits, or cultural values that may be pertinent to the emotional health of the Hispanic population in this country are migration—which has forced separation—and the acculturation process to new values and customs—to which many times there is strong resistance. These issues produce additional stress among many Hispanics, specially on the areas of family structure, ethnic identification, and sex role expectations.²

The most recent immigrants often have feelings of estrangement and displacement due to culture conflict, the disruption of the extended family (bringing feelings of isolation or guilt for abandoning them), language barriers, and added family clashes resulting from intergenerational conflicts caused by differences in rates of acculturation—young people adapting and assuming the new values much quicker.³

Within the Hispanic family circle the emphasis is on cooperation rather than competition, and children are expected to be obedient. Usually they are not consulted on family decisions which may lead Hispanic kids to be less prepared to be assertive and to succeed in the highly competitive world they confront outside.⁴

Interpersonal relationships are strongly emphasized among Hispanics. They are

maintained and nurtured within a large network of extended family and friends, and these are generally seen as the main resource of support and help.⁵ Although this can be an advantage, some authors point out that “along with the many positive features, emotional involvement and financial obligations with a large number of family and friends may also function as an additional source of stress.”⁶ Additional factors, such as discrimination and a more fatalistic approach to life, accepting facts as inevitable and behaving less assertively to change “their fate,” also need to be considered.

Several mental disorder studies deal with ethnic variability. The Epidemiologic Catchment Area Study (ECA), for instance, reports the absence of dramatic variability between Whites, Blacks, and Hispanics; still Hispanics showed the highest one-year prevalence for major depressive disorders, and life prevalence of dysthymia,⁷ and a study on personality characteristics among Hispanic Protestant ministers, showed that “Hispanic Protestant ministers showed statistically significant elevations in scales measuring an ideal image, depression somatization, non-conformity, aggression, and anxiety. . . in comparison to their Anglo counterparts.”⁸

Background of the Research

In addition to genetic-biological, environmental, and psychological-cognitive causes of depression, there are specific health and psychological hazards in ministry—as a helping profession—which were considered in this study. These include the nature of the ministerial work and the demands and expectations of ministry, such as unclear or confusing work boundaries, internal control mechanisms and criteria for measuring work accomplishment, unrealistic expectations, and the stress related to working in a people oriented profession. Loneliness, the narrowing of the minister’s focus, confusing role identity with self-image, financial issues, and the problems with the minister’s family were also considered.

Questionnaires

Two questionnaires were mailed to the 400 Hispanic ministers working in Hispanic churches in the territory of the North American Division. The first one was a cross-cultural survey for the quantitative measurement of depressive symptomatology in normal adults—the Zung SDS Scale—and the second questionnaire was intended as a way of probing major areas of stress and possible factors related to depression in this group. It also tried to identify the support systems these ministers draw—or would be willing to draw—from to cope with this illness.

Several research authors state that Hispanics, although more open to personal interviews, have a very low survey return rate.⁹ Yet, and in spite of the sensitivity of the issues discussed, 229 ministers (57.3%) mailed the surveys back, suggesting that the topic of the study was of great interest to the chosen population.

Demographic Data of Survey Population

The respondents are all males, ranging from 23 to 79 years of age, with a mean of 46.5 years. They come from Mexico, Inter America, the Caribbean Islands, South America, Europe, and the USA; and their educational level vary from BA in theology to EdD or PhD (and in between). Of the respondents, 186 work full time as ministers, and the rest work on a part-time basis; 177 are ordained.

Their ministerial experience ranges from a few months to 60 years, with a mean of 18.5 years in the ministry. They serve in urban, suburban and rural areas and have one to six churches under their care. As to the length of time they have served in their current churches, it varies from 1 to 25 with a mean of 3 years.

Results of the Surveys

The results of the first instrument—the SDS Scale—showed that a total of 53 respondents (23.9%) presented elevated (above normal) levels of depressive symptomatology indicating different degrees of depression: 44 respondents presented minimal to mild depression, 7 respondents presented moderate to marked depression, and 2 respondents showed signs of severe to extreme depression.

A careful look at the answers, though, shows that at least some of the time 50 percent of the respondents feel down-hearted and blue, 46.6 percent have trouble sleeping, and 59 percent are more irritable than usual. Also, there appears to be diminished clarity of mind, capacity to make decisions, and ease to do the things they used to. Although these and other answers may be connected to factors other than depression, such as age or temporary situations, they could also reflect problems of stress and burnout.

The second questionnaire explored nine areas to find out if there were correlations between them and the elevated levels of depression. The nine areas selected are marital and family issues; work-related issues; spiritual issues and devotional life; educational background and intellectual development; life style and physical health; emotional health; social life and support systems; financial issues; and stressful life events. Statistically significant correlations were found with most of these areas demonstrating once again the complexity of this illness which is usually related to a combination of many factors.

The results of the survey show:

- 1) A high level of marital satisfaction (90.7%) with a mean of 21 years of marriage and couple/family relationships as the main source of social and emotional support. Yet, a great need to balance time at home and at work, overcoming the tendency to neglect the family and the self in their dedication to ministerial tasks, can be perceived.
- 2) Tremendous wealth of experience (18.5 years in ministry was the mean) and high commitment of these ministers to their pastoral call, with many comments on the joy and fulfillment they experience in serving God and guiding people to Him. Although 20.7 percent of the respondents have seriously considered leaving the ministry, 87 percent are happy working as pastors.

On the other hand, several answers reflect a somehow distorted vision of what God expects from His ministers which appears to justify the neglect of the family and self referred to above. Furthermore, correlations between elevated levels of depressive symptomatology and the relationship with superiors, the congregation's appreciation of their work, their superior's satisfaction of their jobs, sense of competition among pastors, and the expectations of the SDA church were all statistically significant. These could lead to speculate that motives for being in the ministry, as well as expectations and things from which some ministers derive satisfaction in ministry may need to be reevaluated.

- 3) The respondents' earnest desire for further education and professional growth opportunities. In fact, this was the only area in which all variables showed statistically significant correlation with the elevated levels of depression.
- 4) Ministers' need to take better care of their bodies. Almost 57 percent believe they do too little physical exercise, 85.1 percent work more than 45 hours per week, 56.3 percent do not go the doctor for a regular check-up, and 43.7 percent do not take their weekly day off. In addition, 19.4 percent believe they do not eat a balanced diet, and 32.9 percent sleep less than 7 hours per night. It is essential to understand that ministers are also subject to natural laws, and the effectiveness of our ministry may be sabotaged by the natural consequences of the abuse of our minds and bodies.
- 5) Keen awareness of the need to learn and apply better time management principles. Almost 80 percent of the respondents expressed this need, and difficulties in balancing time was listed as the number one area of difficulty in ministry.
- 6) Work-related issues, financial problems, and family issues were pinpointed by ministers as the main reasons both for past and current depression episodes. Other causes given were health problems, loneliness, broken relationships, unmarried status, grief, personality problems, language difficulties, immigration situation, and problems of morality.
- 7) A tendency to "spiritualize" problems of depression minimizing the physical and psychological implications of the illness. More than 49 percent (N=109) of the respondents answered they had had depression in the past. Although there is no way of knowing how many of them actually experienced depression in the medical sense, these numbers are very high. Yet, 66.1 percent to these ministers considered that a stronger devotional life had been one of the main ways to overcome depression.

This may reflect misunderstanding of depression as an illness and some bias on the options of treatments considered. In fact, only 12.8 percent of them received medical treatment and 28.4 percent resorted to counseling. The support of family and friends, taking care of unsolved issues of the past, change of working place, the support of the conference, additional sources of income, setting achievable goals, and more involvement in social and recreational activities were also listed as ways that helped them overcome

their depression.

If you broke your leg, or had diabetes and you told me that your best treatment was a stronger devotional life, would that sound rational? Don't get me wrong, we would *all* benefit from a closer relationship with God, but that would not solve a broken leg or diabetes; and in most cases it does not solve depression either.

8) The fact that 70 percent of those currently suffering from high levels of depressive symptomatology believe they have suffered from depression in the past is specially worrisome. It also makes my previous point even stronger. This appears to confirm that the real causes of their depressive illness were not found and properly dealt with.

9) An urgent need to develop more social and support systems that may provide ministers with networking, friendship, and counseling opportunities. Actually, this area presented the saddest picture about the struggles of many pastors. A vast majority will turn to their spouses for support, and although this is good, it may not be enough; and what happens when the source for crisis is the marriage itself? Several ministers added heartbreaking personal comments such as, "I have no one to talk to," "in this line of work you can't trust anyone with your problems," and a pastor who presented severe to extreme depression wrote, "I have no one to go to, I don't trust anybody, and I don't want to worry my wife."

It is possible that issues mentioned above—recent arrival, lack of friends and/or extended family in this country, and language barriers—plus negative pasts experiences, fear for their reputations and jobs, and even misunderstanding of some of Ellen G. White's quotations on these topics may have played a role in the development of these attitudes. An astonishing 31.1 percent believe they should seek advise only from God when they are going through personal problems!

On the positive side, a great number of pastors would like to see things differently; 82.4 percent agree that more opportunities to work and fellowship with fellow pastors would benefit their ministry greatly. These and other measures could also provide social and support opportunities which appear to be one of the most vital needs of this survey population.

Indeed, a healthy and balanced lifestyle—involving the spiritual, mental, physical, and social aspects of life—is the most effective antidepressant. Not only is it critical in preventing depressions but it also provides the best healing alternatives.¹⁰ The last article on this series will make suggestions on how to achieve this balance in our lives.

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1. U.S. Department of Commerce, *Statistical Abstract of the United States* (Washington, DC: Bureau of the Census, 1997)), 12-65.
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 3. *Ibid.*, 237.
 4. *Ibid.*, 230, 231.

5. C. Carillo, "Changing Norms of Hispanic Families," in E. E. Jones and S. J. Korchin, eds., *Minority Mental Health* (New York, NY: Praeger, 1982), 250-266.
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8. Pablo Polischuk, "Personality Characteristics and Role Preferences among Hispanic Protestant Ministers" (Ph.D. dissertation, Fuller Theological Seminary, 1980), 137-138.
9. William G. Zikmund, *Business Research Methods* (Fort Worth, TX: Dryden, 1997), 246-251.
10. William Hulme and Lucy Hulme, *Wrestling with Depression* (Minneapolis, MN: Augsburg, 1995), 77.

**A Study on Depressive Symptomatology among Hispanic Ministers
of the North American Division of Seventh-day Adventists
Part III**

Christians have been given excellent resources for preventing and coping with physical and emotional illnesses, even though these measures do not exempt them completely from experiencing illnesses and pain.

Preventive measures

A healthy and balanced lifestyle—involving the spiritual, mental, physical, and social aspects of life—is the most effective antidepressant. Not only is it critical in preventing depressions but it also provides the best healing alternatives.¹ Among the resources available to achieve this balance are:

1. **Physical Resources:** Depression is tied to our physiology as much as it is to our psychology. We need to learn to take care of our body among other things by eating a proper diet, increasing our physical activity, resting and taking time out, and seeing our doctor regularly.

Too many Adventist ministers preach against addiction while they themselves are being addicted—to work! If you are proud of overwork, you may well have both an ego problem and a theological problem. Get your sleep each night. Take your day off each week. Take your vacation each year. Jesus would. Although He had only three and a half years to get His work done, He made sure His disciples got their rest. On several occasions He took them aside for the purpose of resting.²

2. **Mental Resources:** Introduce changes in your attitudes and actions by watching your thought patterns, including laughter and fun in your life, and finding pleasure in other activities in addition to the ministerial tasks.

3. **Spiritual Resources:** These include all spiritual exercises such as taking time to be alone with God, reading the Bible and praying, expressing praises and gratitude to God, and trusting in Him. “Devoting some time each day to our spiritual health, especially to prayer and Bible meditation, is an antidepressant.”³

4. **Family resources:** Just as marital problems are among the most common precipitators of depression, marital satisfaction and family unity can provide strong factors

of emotional stability. Dr. Roger L. Dudley suggests the following essential things:⁴ be faithful and loyal to each other, share marital intimacy, devote sufficient quality time to each other, communicate deeply with your wife and children, respect and affirm each other and the kids, and make family worship a priority.

After God, our family should be our first priority. “Nothing can excuse the minister for neglecting the inner circle for the larger circle outside. The spiritual welfare of his family comes first.”⁵

5. **Educational and Professional Resources:** Just as physical fitness requires regular exercise, continuing education provides fitness for the mind. Pastors should diligently search for ways to improve their work, and administrators should explore ways to increase the capabilities of ministers and multiply their fruitfulness.⁶

What can ministers do? Set aside daily time for study, attend seminars, and take advantage of all opportunities offered for continuous education, enrichment and growth.

What can seminaries do? Address the “whole person” in ministry, counteract the cultural ideal of self-sufficiency, provide special training in practical areas—such as conflict resolution, difficult personalities, communication problems, time and finance management, authority and delegation—and keep in touch with alumni offering enrichment short-term classes or alternatives during crisis periods in the process of the career development.

What can conferences do? Provide annual opportunities for continuous education, equip ministers with the necessary tools for growth, offer mentoring programs for pastors who are entering the ministry, and study the possibility of granting ministers three-to-six-month sabbaticals every five to seven years as a door to renewal, regaining of perspective, and recovery of enthusiasm, meaning and direction.

6. **Social and Support Resources:** God should be our main source of support, but it is important to understand that He never intended to be our *only* source of support. He works through many means. Every minister needs close confidants to help him with his professional and personal conflicts, and if steps are not deliberately taken to develop these supportive relationships, the loneliness of ministry will lead to isolation, professional ineffectiveness, and a distortion of reasoning which may lead many ministers to depression.⁷

Both the Bible and Ellen G. White strongly support this idea, and the SDA’s Ministers Handbook advises us in this regard: “Should pastors have intimate friends? Absolutely. Close, trustworthy, bare-your-soul friendships are not only permissible, but a sign of relational competence and emotional maturity.”⁸ Among the sources of social support ministers can draw from are family and friends, colleagues, conference leaders and services, church congregations, and professional resources such as professional counseling, career development centers, psychologists, and psychiatrists.

7. **Financial Resources:** Ministers, as everybody else, need to manage wisely the financial resources God has entrusted them. To achieve this, it is important to prepare a monthly budget and follow it carefully, save some money for the “rainy days,” invest wisely, give careful consideration to taking loans, and avoid getting trapped in the credit

cards' "spider webs." Attending seminars and workshops on money management and investment strategies could be very useful.

Conferences could help by assessing periodically what a fair minister's salary should be: "their financial resources should match their economic demands. This may mean increasing salaries or benefits, paying the spouse for work done in the church, or allowing or helping the spouse to find other work,"⁹ specially when frequent moves make it difficult for ministers' spouses to get good jobs, promotions, or other opportunities.

8. **Work-related Resources:** Changes in some attitudes and working habits could help us to be more effective and less prone to depression in our ministerial task. We need to acknowledge our humanness, know our strengths and weaknesses, and set up realistic expectations of our high calling.

Each day brings its responsibilities and duties, but the work of tomorrow must not be crowded into the hours of today. God is merciful, full of compassion, reasonable in His requirements. He does not ask us to pursue a course of action that will result in the loss of physical health or the enfeebling of the mental powers. He would not have us work under a pressure and strain until exhaustion follows, with prostration of the nerve.¹⁰

Furthermore we need to understand that we can't please everybody even though we should listen to others and be flexible in our opinions. Assertive skills, handling our anger in positive ways, and developing a Biblical balanced theology of both failure and guilt can also be effective resources. In addition, it is essential that we learn to manage our time better, setting priorities, aiming for realistic goals, learning to delegate responsibilities, and saying no when necessary.

Finally, what about your motives for being a minister? Are we consciously or unconsciously working for recognition, love, appreciation, or even to make up for a deficient ego? Love for God should be our only motive, and we should strive to serve and obey Him. Knowing we do that to the best of our abilities is our best reward.

What can conferences do? They can train laypeople on the roles, expectations, and limitations of the pastor and his/her family. Some excellent tools were provided during 1993—the year of the Adventist minister—but ongoing education is needed to help laypeople understand and support their pastors better. This appears to be specially needed among Hispanic congregations which, according to comments made by several ministers in the surveys, are more demanding and have higher expectations of their pastors than their Anglo counterpart.

Conferences could also restudy the frequency of pastoral moves. The stress of moving, both emotional and physical is significant. Indeed, frequent moves was listed as the second most difficult thing about being in the ministry by survey respondents. Not being able to put down roots, academic adjustments for kids in school, and spouses changes of job and the financial strain that causes were some of the reasons given.

God is the main reservoir of strength for physical, intellectual, emotional, social, and spiritual health. But He expects in this—as in every other aspect of our lives—our proactive participation by making a wise use of all the resources He has made available to us to prevent and/or to overcome depression.

Coping mechanisms

If you are suffering from depression, remember that there are ways to shorten and alleviate your suffering, and to prevent it from becoming recurrent. Be patient with yourself and give yourself time to deal with this illness, just as you would if you were suffering from cancer or a broken leg, but keep in mind that complete recovery will take place only after the illness has been appropriately treated. Here are a few advises:

- * *Acknowledge your depression and seek professional help:* Don't let biases and misconceptions prevent you from getting the appropriate help.
- * *If you are having suicidal thoughts:* You need to see a doctor right away. Do not postpone it, get help NOW.
- * *Learn as much as you can about depression and its treatment:* Knowledge may be your most powerful weapon.
- * *Learn from past depressions:* Identify what has triggered past episodes of depression.
- * *Understand your own physiology:* Tolerance to stress, and predisposition to fatigue and adrenal exhaustion varies from person to person. Know yourself and accept your own limitations.
- * *Deal with your guilt:* If there are unconfessed sins in your past you need to resolve those issues. Sins need to be confessed and forsaken (1 Jn 1:9), and God's forgiveness secured to enjoy mental health. But beware! This *does not* mean that if you are suffering from depression it is because there are unconfessed sins in your past! Many reasons, other than spiritual ones, play a role in the development of depression.
- * *Correct your thought patterns and avoid helplessness:* Yet, getting problems off your mind and changing your thought patterns may be very difficult if you are severely depressed. If you feel that there is nothing you can do to change your circumstances, if you have tried to change your negative thought patterns and failed, and that makes you feel guilty, ashamed, and even more depressed, you need professional help.

The SDA Ministers Handbook advises:

... you will need some special help from other people at times. This may come from your spouse, a fellow pastor, a friend, or a support group. Some conferences/missions have a plan to pay anonymously at least part of the fee for counseling with a professional counselor. Don't be too embarrassed or proud to accept counsel. Plan your life around the expectation that 'we all need help sometimes.'¹¹

- * *Take time for relationships:* Do not underestimate the importance of social and support systems to help you out of your crisis.

* *Trust in God:* Even if your present looks bleak, trust in God! He may still bring something good out of this! People who have never hurt are sometimes insensitive to sadness, failure, and sickness and may be even intolerant of people suffering with those problems. Ministers can make their own wounds available as a source of healing to others. As Robert Raines put it: "Our wounds are the visa into the country of another person's deep being."¹²

How can conferences help? By showing an open attitude and supporting their minister in every possible way. When the crisis is over, these ministers will not only be productive employees again, but they will probably be more valuable because of their deeper understanding of human sufferings.¹³ Additional help may involve encouragement to seek appropriate treatment, suggestions of further education or training, the possibility of a job/district change, or offers of a sabbatical. Understanding, love, and concern will undoubtedly be the greatest help that any employer can give.

Curative alternatives

The nature and severity of the problem will determine where to find help. The first step may be to see the "family doctor." He can provide referrals to mental health specialists if needed. Help for depression is available through community mental health centers, state and local health department, hospitals, clinics, and private practices.

Most patients can be effectively treated on an outpatient basis, hospitalization is necessary only when a patient is an immediate danger to him or herself or others. Mild depressions can be handled by a competent counselor, clinical social workers, or experienced pastoral counselor. More serious depressions and those that appear to be repetitive should be treated by a clinical psychologist or a psychiatrist who is experienced in working in a hospital setting. Whenever possible seek treatment by someone who shares your Christian faith.

Depressive illness is generally best treated with a combination of medication and psychotherapy. Other methods of treatment include bright-light therapy, nutritional approaches, dietary supplements, and other promising alternatives.¹⁴ A critical issue here is the importance of sticking to the treatment prescribed until the right medication/s or treatments are found. Family can be of great help here.

Therapy for depression can show results quickly, usually in a matter of weeks, but learning skills for coping in the future should be an area of continuous personal growth. Biological treatments for depression are dramatically effective. Eighty percent, or even more, of individuals suffering a major depression will respond to one or another of the antidepressant drugs, singly or in combination.¹⁵

Keep in mind that just as Job was used mightily by God *after* his time of depression, Elijah's emotional breakdown did not prevent him from being one of the greatest prophets of all times, and Moses, David and other men and women of God were able to overcome depression, so can any of us who is experiencing this illness. From the way God dealt with Elijah's depression we can learn that "God really cares for us and that crises through which we may go are just that—temporary crises in which we can count on the ministry of God

from many different sources—so that we again become people who enjoy living and enjoy ministering.”¹⁶

As ministers, in the course of our lifetime we will have the privilege and challenge of touching many lives in a highly personal way, but we shouldn’t forget to allow ourselves to be ministered to as well. Each investment in the physical, intellectual, emotional, social, and spiritual health of our own lives will touch many others.¹⁷ So our challenge is to learn how to “burn ourselves” in the service of the Lord without being consumed, how to care for ourselves in addition to caring for those God has entrusted to us, and how to keep physically and psychologically healthy through work, rest, recreation, continuous education, disciplined living, forgiveness, and supportive relationships. That is the critical balance of pastoring!

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APPENDIX F

OUTLINE FOR A SEMINAR ON DEPRESSION

OUTLINE FOR A SEMINAR ON DEPRESSION

Part I - Depression in Ministry (1 ½ hours)

- § Introduction
- § Brief history of depression
- § Realities of depression in our age
- § Depression in the Bible
- § Ellen G. White's comments on depression
- § Depression among ministers

Part II - Recognizing and Understanding Depression (1 ½ hours)

- § Types of depression
- § Symptoms of depression
- § Differentiating depression from stress and burnout
- § Causes of depression
 - Genetic-Biological and Environmental Causes
 - Psychological-Cognitive Causes
 - The Emotional Hazards of Ministry
- § Consequences of Depression

Part III -A Study on Depressive Symptomatology among Hispanic Ministers of the NAD (1 ½ hours)

- § Why among Hispanics?
- § The survey instruments
- § Demographic data of the research population
- § Results
 - Zung SDS Scale
 - Questionnaire for pastors
- § Summary, limitations, and conclusions

**Part IV - Preventing and Coping with Depression
(1 ½ hours)**

- § Preventive measures and resources available
- § Coping mechanisms
- § When the minister's spouse is depressed
- § Curative alternatives
- § Conclusion

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