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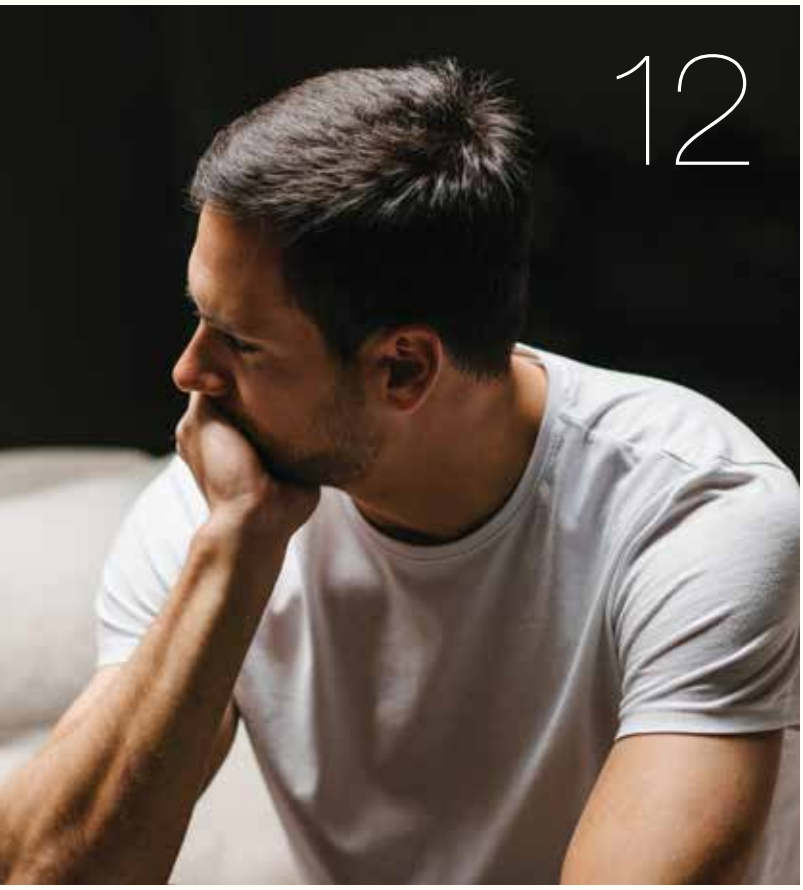

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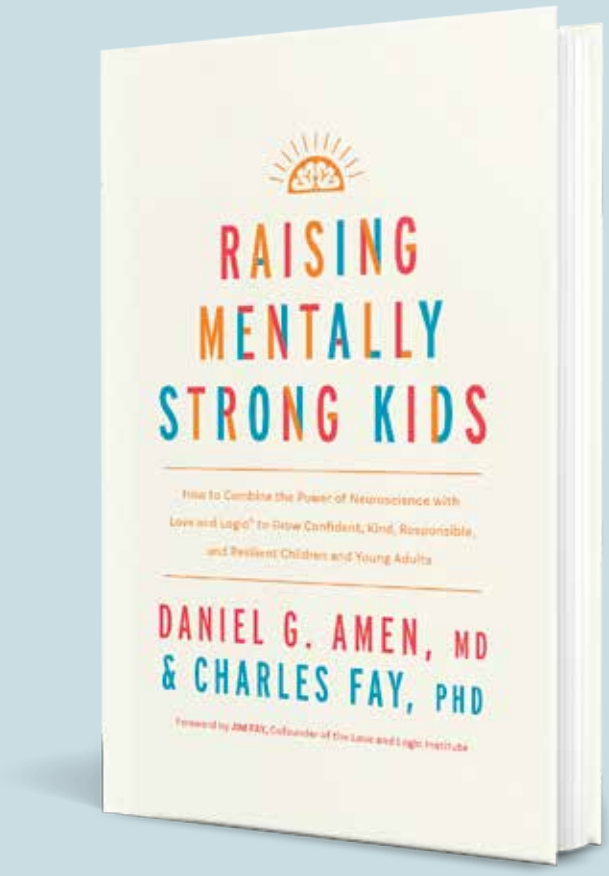

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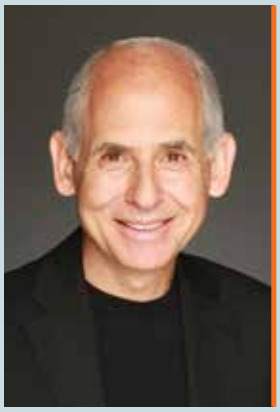

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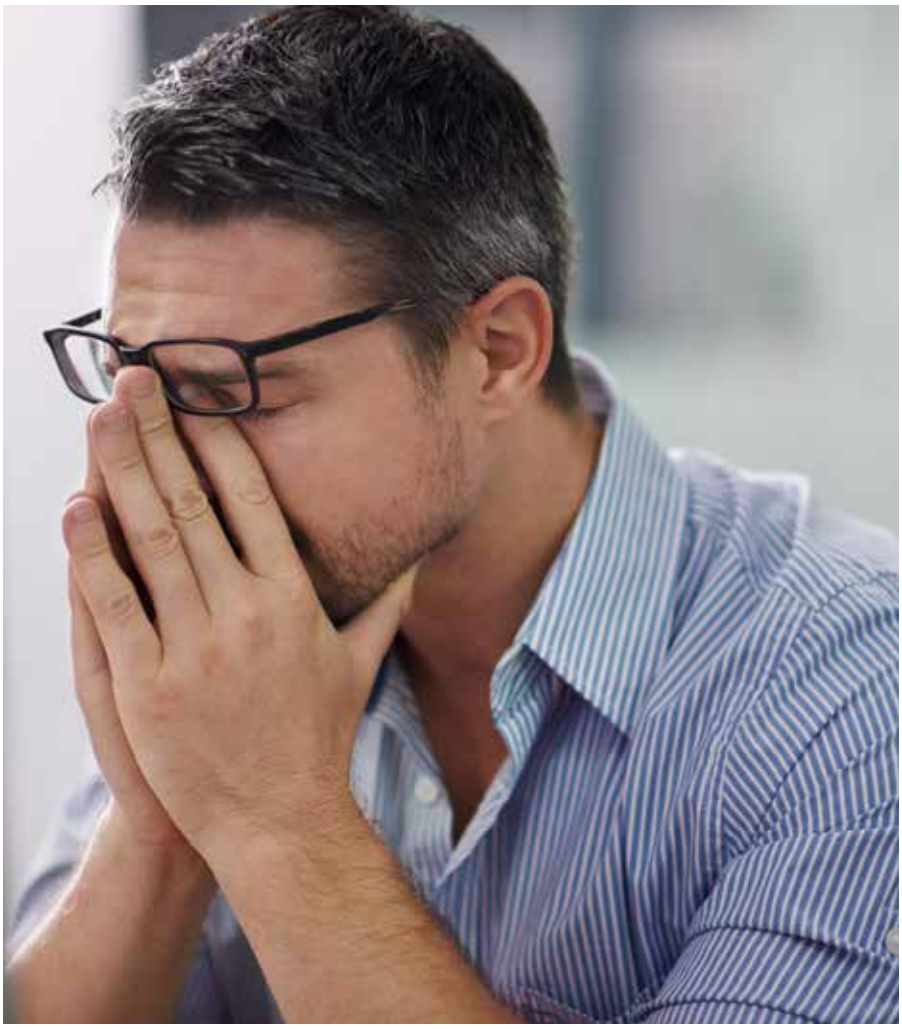
« TIM CLINTON, ED.D., LPC, LMFT, BCPCC

A Peace that Passes All Understanding

In 2020, the World Health Organization (WHO) reported that depression had become a leading cause of disability worldwide, warning of its potential to emerge as a global epidemic.[1] It seems we have gotten there with great intensity. Depression is climbing at alarming rates, fueled by loneliness, the rise of digital addiction, the fallout of the COVID-19 pandemic, and the breakdown of traditional support systems. Depression, a common psychological disorder, affects about 280 million people worldwide.[2] This surge raises urgent questions for those of us on the front lines of mental health. How do we help calm the restless minds flooding our offices? How do we offer hope in a world that feels increasingly untethered?



How We Got Here

People are desperately searching for help and hope. It does not take much to notice that our world has changed dramatically over the last few years. One of the most significant shifts driving the depression crisis is the collapse of family and community. For centuries, we depended on each other—family, friends, and faith communities. These networks were the glue that held us together.

However, today, neighborhoods that used to hum with kids outside playing together and families talking now feel eerily quiet. We retreat behind screens instead of stepping outside to chat with a neighbor. Churches and other places of worship, long staples of belonging, have seen attendance dwindle in many areas. The result? A profound sense of isolation.

We have lost the very spaces where we are supposed to share life's joys and struggles. And when people feel disconnected, depression is often not far behind. What we are seeing in the latest research backs this up—strong social ties act as a protective factor against depression. Yet, the very structures supporting those ties are crumbling before our eyes.

The Next Generation

Our kids are in trouble. They are facing challenges we could not have imagined in earlier generations. Academic pressure feels relentless, and the obsession with social media and economic uncertainty casts a long shadow over their futures.

And what especially worries me is that they are essentially walking this road alone. The rites of passage that once helped young people confidently transition into adulthood have all but faded. Where are the mentors and elders who could guide them through life transitions and chaos?

Instead, our kids turn to social media for direction and validation—a double-edged sword. While the Internet community promises connection, it often delivers comparison, envy, and a sense of inadequacy. The

Smartphones, never-ending work demands, and the relentless push to social media have kept us wired. We have normalized a culture in which sleep deprivation and good health are all but a badge of honor. However, the consequences are devastating.

curated perfection they see online only amplifies feelings of alienation. This is not just a youth problem; it is a societal crisis. Jonathan Haidt, the author of *The Anxious Generation: How the Great Rewiring of Childhood is Causing an Epidemic of Mental Illness*, has sounded a massive six-fire alarm. The rising rates of depression and anxiety in this generation are a wake-up call. We cannot afford to ignore the pressure cooker in which they are living.

The Pandemic's Fallout

The COVID-19 pandemic poured gasoline on an already burning fire. Social distancing measures tore apart the fabric of human connection. Isolation became the norm, fear was everywhere, and uncertainty was the backdrop to our daily lives.

For many, the pandemic introduced a brand-new battle on our mental health. Anxiety and depression skyrocketed. Frontline workers bore the brunt of unimaginable stress. Loss tore families apart, and financial instability left millions powerless.

Sleep, one of the first casualties of this global crisis, became a distant memory for countless individuals. Let's not underestimate the role of sleep in mental health—it is vital. A restless mind does not shut off easily, and sleep deprivation quickly becomes both a symptom and a cause of depression. Emotional regulation breaks down without adequate rest, leaving people even more vulnerable to despair. Sure, telehealth services stepped up during this time, which was a lifesaver for many. However, the sheer scale of the overwhelming need revealed the extent of our inadequately prepared mental health system.

The Sleepless Generation

Even before the pandemic, we were on the path to becoming a nation of restless minds. Smartphones, never-ending work demands, and the relentless push to social media have kept us wired. We have normalized a culture in which sleep deprivation and good health are all but a badge of honor. However, the consequences are devastating.

Sleep is not just about feeling rested—it is foundational to secure mental health. A lack of sleep disrupts cognitive function, emotional stability, and physical health—all essential for managing depression. For many, nighttime is when the battle with a restless mind peaks. 2:00 a.m., 3:00 a.m.—the stillness of night amplifies intrusive thoughts and worries, robbing people of the rest they desperately need. It is a vicious cycle, and breaking free is not easy.

The Rush That's Breaking Us

Our modern pace of life leaves no room for breathing, let alone healing. It is a rush from the moment we wake up until our heads hit the pillow—if they ever do. Careers, relationships, social media, and endless to-do lists demand our attention, leaving us exhausted and emotionally spent.

The problem is that when we are always in a rush, we do not allow time to process our feelings. We push our emotions aside, telling ourselves we will deal with them later… but later never comes. Instead, burnout creeps in, and depression follows close behind. Slowing down might sound counterintuitive, but it is precisely what we need.

The Road Forward

So, how do we move forward? How do we help people calm their restless minds and find hope again?

Let's start by talking about purpose. I believe this is something we have lost. A sense of meaning can be a powerful antidote to depression. When people feel their lives have a purpose, they are better equipped to handle life's challenges. For many, faith is the cornerstone of finding a meaningful and purposeful life. A personal relationship with God and a commitment to His mission offer a powerful lens through which we can make sense of suffering and cling to hope, even when all hope seems lost.

Other common practices, such as gratitude and service, can also help. These habits shift the focus away from ourselves, breaking the cycle of self-absorption that depression often feeds on.

Rebuilding the Family

Family should be the bedrock of stability and resilience—a haven in a chaotic world. But let's face it… the family unit is under tremendous pressure. Economic strain, rising divorce rates, and the demands of modern life make it more challenging than ever to put family first. Still, investing and anchoring in these relationships is one of the most effective ways to combat depression.

Simple things like eating together or having something meaningful to talk about make all the difference. Intergenerational bonding, such as the wisdom shared between grandparents and grandchildren, is a form of stability that no amount of money can buy.

A Call to Action

The epidemic of clinical depression and restless minds is a reflection of the times we are living in today. But it is not hopeless. In fact, within this crisis lies an opportunity for renewal. We need to rebuild families and communities—not by clinging to nostalgia, but by creating spaces where people can truly connect. We must use technology wisely and focus on developing opportunities for authentic relationships instead of shallow interactions—like eating together, playing together, and going to church and praying together. It is imperative that we prioritize faith, family, and purpose as the cornerstones of a healthy life.

Somehow and in some way, as we press in toward God and each other, we must grasp the peace that passes all understanding, which we read in Philippians 4:7. If we are willing to slow down, reconnect, and invest in what really matters, we can help people find peace in the midst of chaos. ✠

TIM CLINTON, ED.D., LPC, LMFT, BCPCC, is president of AACC, the world's largest and most diverse Christian counseling association. He is also Executive Director of the Global Center for Mental Health, Addiction, and Recovery and Professor Emeritus at Liberty University. For seven years, Dr. Clinton served as co-host of Dr. James Dobson's Family Talk, heard on more than 1,400 radio outlets daily, and now hosts a weekend television program, The Road Forward, seen on Real America's Voice News streaming service and numerous platforms. He and his son, Zach, also co-host a national daily radio broadcast, Life, Love, Faith, and Family, focusing on mental health and relationships.

Endnotes

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AN OVERVIEW OF CLINICAL DEPRESSION:

What We Know and What Can Be Done

"The LORD is close to the brokenhearted and saves those who are crushed in spirit."
– Psalm 34:18, NIV

PREVALENCE

Those crushed in spirit are on the rise. Unfortunately, the upward trend during COVID has continued, even with the shift from pandemic to endemic. The Gallup organization tracks, among other things, rates of depression in U.S. adults. According to their 2023 findings, "… the percentage of U.S. adults who report having been diagnosed with depression has reached 29%, nearly 10 percentage points higher than in 2015. The percentage of Americans who currently have or are being treated for depression has also increased to 17.8%, up about seven points over the same period. Both rates are the highest recorded by Gallup since it began measuring depression using the current form of data collection in 2015."[1]

Gallup's statistics included those who *have or are treated for depression*. What about those who are not diagnosed or treated? A 2022 study titled "Prevalence and Impact of Diagnosed and Undiagnosed in the United States" found: "Only 39.4% of respondents indicated that they had a formal diagnosis of depression. In contrast, 53% of participants have considered seeking help from a mental health professional. More importantly, 31.45% of respondents without a formal diagnosis had a PHQ-9 score of over 10 (moderate to severe depression)."[2]

According to Gallup, rates of depression are rising faster for certain demographic groups: "Over one-third of women (36.7%) now report having been diagnosed with depression at some point in their lifetime, compared with 20.4% of men, and their rate has risen at nearly twice the rate of men since 2017. Those aged 18 to 29 (34.3%) and 30 to 44 (34.9%) have significantly greater depression diagnosis rates in their lifetime than those older than 44. Women (23.8%) and adults aged 18 to 29 (24.6%) also have the highest rates of current depression or treatment for depression. These two groups (up 6.2 and 11.6 percentage points, respectively), as well as adults aged 30 to 44, have the fastest-rising rates compared with 2017 estimates. Lifetime depression rates are also climbing fast among Black and Hispanic adults and have now surpassed those of White respondents."[3]

"So my spirit grows faint within me; my heart within me is dismayed."
– Psalm 143:4, NIV

TYPES

Depression is a complex condition, affecting people in different ways at different times. According to the National Institute of Mental Health (NIMH), the two most prevalent types of depression are:

- Major depressive disorder, with symptoms of depressed mood and lack of interest for a majority of time, over at least two weeks, resulting in disruption of daily activities
- Persistent depressive disorder, also called *dysthymia* or *dysthymic disorder*, with less severe depressive features over an extended period, usually for at least two years

Other types of depression include:

- Depression with psychotic features, such as delusions or hallucinations
- Bipolar disorder, combining depressive and manic episodes

Depressive female subtypes include:

- Premenstrual dysphoric disorder, a more severe form of premenstrual syndrome
- Perinatal depression, a form of depression occurring during or after childbirth for at least two weeks but lasting up to three years[4]
- Perimenopausal depression, affecting some transitioning to menopause[5]

GREGORY L. JANTZ

The current *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5-TR*) lists additional depression subtypes:

- Disruptive mood dysregulation disorder, new to the *DSM-5* and the only diagnosis in the depressive disorder category requiring childhood onset, with features of severe, recurrent temper outbursts[6]
- Substance and medication-induced depressive disorder, with symptoms of depressed mood or marked loss of interest in all or almost all activities, occurring during or soon after substance intoxication, withdrawal, or exposure to medication[7]
- Depressive disorder due to another medical condition, developing depressive symptomology due to a medical condition[8]

"The LORD said to Cain, 'Why are you angry, and why has your face fallen?'"
– Genesis 4:6, ESV

ETIOLOGY

Answers to the "why" of depression are not easily ascertained or derived from a singular focus. The "whys" can proliferate from a bewildering array of potential origins, multiple co-morbid contributors, and conjectured causes, a list seeming only to expand.

The Mayo Clinic lists the following causes of depression:

- Physical, structural brain changes are shown to be present in some with depression
- Brain chemistry alterations in the function and effect of neurotransmitters
- Hormonal changes from medical conditions, such as thyroid-based, pregnancy, post-pregnancy or menopause
- Inherited traits present in direct relatives, indicating a level of genetic predisposition[9]

The Harvard Medical School adds:

- Nerve cell implications, including connections, growth, and functioning of nerve cell circuits

- Functioning of the amygdala and the thalamus, as well as the basal ganglia and hippocampus, with research showing the latter smaller in some depressed individuals[10]

The National Institute of Mental Health (NIMH) lists other possible causes, such as:

- Major life changes, trauma and/or stressors
- Serious medical conditions, especially those in middle or older age, such as diabetes, cancer, heart disease, chronic pain, and Parkinson's disease
- Medications taken for an illness, some of which can cause depressive symptoms
- Gender-related implications, with females diagnosed more frequently than males, suggesting males may be "less likely to recognize, talk about, and seek help for their feelings or emotional problems," leading to "a greater risk of their depression symptoms being undiagnosed or underrated"[11]

Other contributing causes include:

- Geographic locations, such as living in colder, darker climates that may contribute to seasonal affective disorder (SAD)
- Lifestyle factors, such as increased screen time, poor sleep, poor nutrition, inadequate physical activity, excessive consumption of alcohol, smoking or substance use, or isolation from social relationships or pleasurable, relaxing activities[12]
- Cumulative effects, based on the diathesis-stress model, where outside factors from a variety of causes combine with cognitive, interpersonal, and personality features to increase the likelihood of depression[13]

"Hope deferred makes the heart sick, but a longing fulfilled is a tree of life."
– Proverbs 13:12, NIV

LATEST REASONS FOR HOPE

To those struggling to overcome depression, it can appear as a long, dark tunnel from which there is no escape. Attempting to minimize the pain or compel some form of artificial remission through a "just get over it" attitude fails to recognize depression's debilitating—and, sometimes, entirely appropriate—response to the pressures of life. So, what can clinicians do to help those plummeting toward their personal "rock bottom?"

The author, J.K. Rowling, is credited with saying, "Rock bottom became the solid foundation on which I rebuilt my life."[14] Psalm 62:5-7 (NIV) says, *"Yes, my soul, find rest in God; my hope comes from him. Truly he is my rock and my salvation; he is my fortress, I will not be shaken. My salvation and my honor depend on God; he is my mighty rock, my refuge."* Rock bottom may be just the place to rediscover hope.

A recent article in *Psychology Today* highlighted a study showing the current most effective treatments for depression.[15] The article cited:

- Psychotherapeutic interventions, such as cognitive behavioral therapy, brief psychodynamic therapy, behavioral activation, mindfulness-based therapy, interpersonal therapy, and problem-solving therapy
- Pharmaceutical antidepressant medications, alone and in conjunction with psychotherapy
- Hormonal therapies[16]

Because we understand depressive symptoms are worsened by poor and disrupted sleep, I would like to add another avenue of hope—cognitive behavioral therapy for insomnia (CBT-i). A 2019 study on the effectiveness of CBT-i found, "Sleep disruptions contribute to a variety of medical problems, including cognitive impairment,

Attempting to minimize the pain or compel some form of artificial remission through a "just get over it" attitude fails to recognize depression's debilitating—and, sometimes, entirely appropriate—response to the pressures of life.

reduced immune function, metabolic imbalance, and exacerbation of psychiatric conditions. The most effective nonpharmacological treatment for chronic insomnia is cognitive-behavioral therapy for insomnia (CBT-i)." There is hope to be found in the five components of CBT-i: sleep consolidation, stimulus control, cognitive restructuring, sleep hygiene, and relaxation techniques.[17]

Our challenge as clinicians is to find ways to stay ahead of the cresting wave of depression. Our confidence comes through believing in a loving God who understands those challenges and actively works with and through us to meet—and overcome—them.

GREGG JANTZ, PH.D., *is the founder of The Center • A Place of HOPE (www.aplaceofhope.com), a healthcare facility in Edmonds, Washington, which emphasizes whole-person care, addressing the emotional, relational, physical, and spiritual aspects of recovery. He is the author of multiple books, including his latest,* Triumph Over Trauma, *and* Here Today, Ghosted Tomorrow. *Dr. Jantz is a sought-after speaker in person and on television and radio (www.drgregoryjantz.com).*

Endnotes

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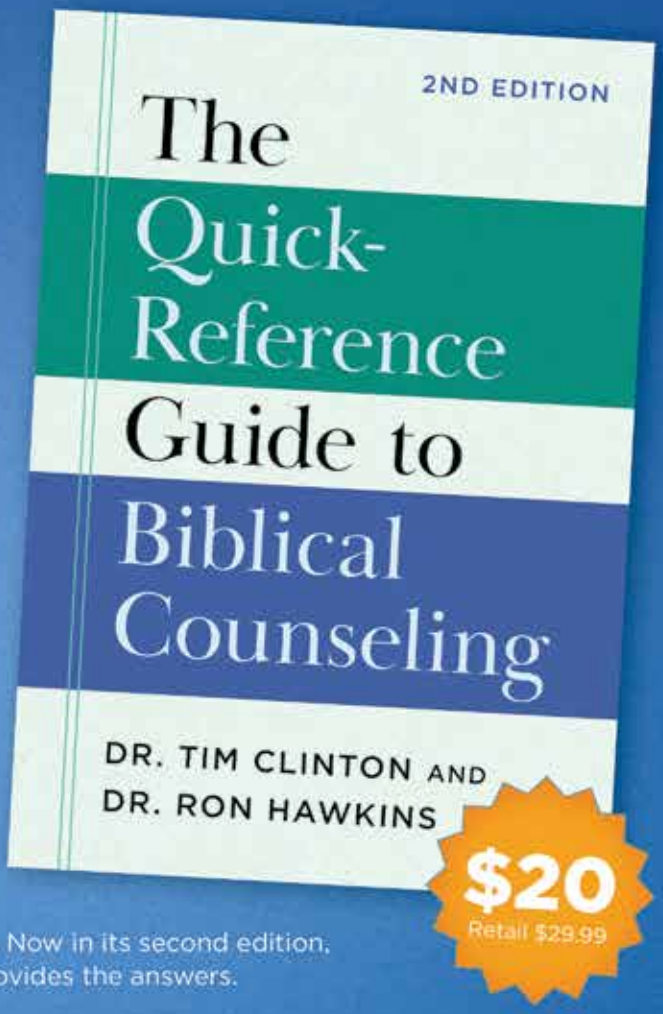

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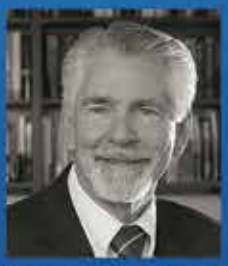

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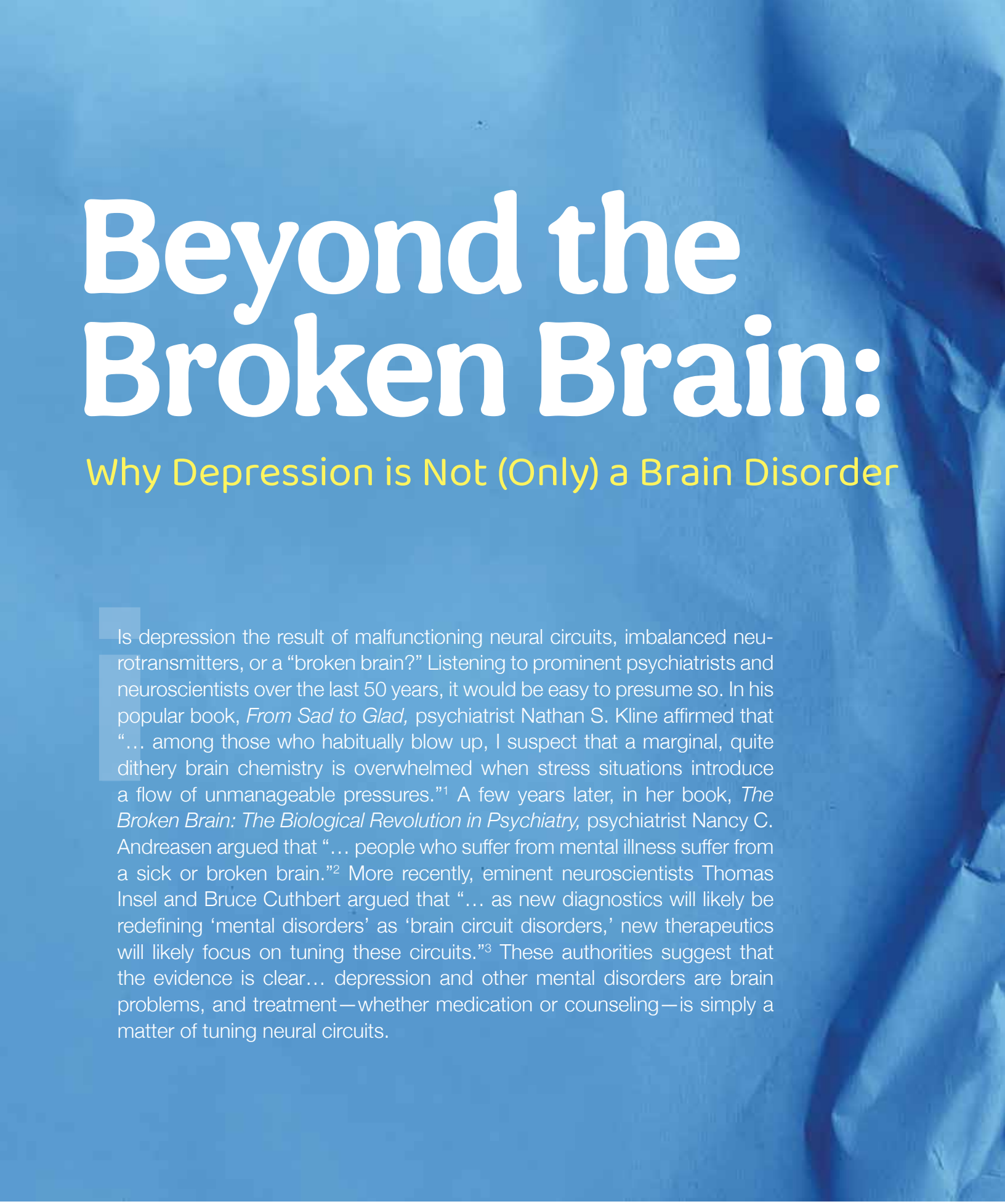

Beyond the Broken Brain:

Why Depression is Not (Only) a Brain Disorder

Is depression the result of malfunctioning neural circuits, imbalanced neurotransmitters, or a "broken brain?" Listening to prominent psychiatrists and neuroscientists over the last 50 years, it would be easy to presume so. In his popular book, *From Sad to Glad,* psychiatrist Nathan S. Kline affirmed that "… among those who habitually blow up, I suspect that a marginal, quite dithery brain chemistry is overwhelmed when stress situations introduce a flow of unmanageable pressures."[1] A few years later, in her book, *The Broken Brain: The Biological Revolution in Psychiatry,* psychiatrist Nancy C. Andreasen argued that "… people who suffer from mental illness suffer from a sick or broken brain."[2] More recently, eminent neuroscientists Thomas Insel and Bruce Cuthbert argued that "… as new diagnostics will likely be redefining 'mental disorders' as 'brain circuit disorders,' new therapeutics will likely focus on tuning these circuits."[3] These authorities suggest that the evidence is clear… depression and other mental disorders are brain problems, and treatment—whether medication or counseling—is simply a matter of tuning neural circuits.

WARREN KINGHORN

In one sense, it is obviously true from a Christian perspective that depression, like every other form of mental distress, happens in our bodies. The Bible affirms the importance of our bodies for who we are. Genesis 2:7 (ESV) teaches that when God created the first human, he *"… formed the man of dust from the ground and breathed into his nostrils the breath of life, and the man became a living creature."* We are dust animated by the breath (Spirit) of God. Because we are dust, Christians have nothing to fear from research that displays how depression shows up in our brains and bodies. Christians can embrace this research as an opportunity to appreciate how we are *"fearfully and wonderfully made"* (Psalm 139:14).

But it is a step too far to claim that depression is *simply* a problem of the brain or body. Depression is not only a matter of the brain. It involves our relationships, our culture, and our world.

First, being humble about the state of psychiatric science is important. While decades of research have produced a great deal of valuable information about depression—including helpful information for guiding current and future therapies—we are still a long way from having any compelling and adequate biological explanation for it. As a historian of science, Anne Harrington described in her book *Mind Fixers: Psychiatry's Troubled Search for the Biology of Mental Illness*, the neurosciences have convincingly shown that depression *involves* the brain, but they have not demonstrated that depression is *only* a problem of the brain.

From a Christian perspective, this, too, should be obvious because we believe that human beings are more than our brains. As previously mentioned, we are not only dust… we are dust that God has breathed into life. Our experience and sense of who we are take form in our relationships with God, with the created world around us, and with other human beings. Throughout our lives, in times of peace and struggle, we develop as *selves* in response to others. We are biosocial beings, embodied *and* relational. While neuroscientists continue to search for biological contributors to depression, counselors and other clinicians (including psychiatrists like me) would do well to focus our energies on well-established *social* contributors to depression, including unresolved trauma, loneliness and social isolation, lack of relational safety, absence of meaning and purpose, and toxic shame. To be sure, genetic and other bodily factors matter. However, it is not helpful to assert that depression is a brain disorder when most of the contributors to depression that we can identify are social and relational in nature. It would be more honest to say that, in most cases, depression is an embodied response to deep social and relational challenges.

If depression is a brain problem, then it is a medical problem just like any other illness and, therefore, nothing to be ashamed of.

Why, then, is the image of depression as a brain disorder or the product of a "chemical imbalance" so deeply held in our culture? Partly, no doubt, it has to do with past and current marketing by the pharmaceutical industry and medical leaders who benefit from the prescription and sale of antidepressant medications and other technologies. But mostly, I believe people affirm that depression is a brain disorder as a way to decrease stigma. If depression is a brain problem, then it is a medical problem just like any other illness and, therefore, nothing to be ashamed of.

Unfortunately, this is a dubious strategy for avoiding stigma. In two meta-analytic literature reviews published in 2013, a group of social scientists showed that "biogenetic" explanations for mental illness were, indeed, associated with reduced self-blame among those who were diagnosed. However, biological explanations also left patients more pessimistic about recovery. Furthermore, when others perceived that someone has a disorder rooted in biology rather than life experiences, they were more likely to want to keep their distance from that person and perceive them as dangerous.[4] Labeling depression as a biological problem is not, in other words, a consistent way to avoid stigma. In some ways, it may make it worse.

What, then, should Christian counselors do when clients wonder if they are depressed because something is wrong with their brains? I suggest four guiding principles.

First, when clients state that their depression is due to a chemical imbalance or brain problem or wonder about this, counselors should seek to understand where the question came from and why it is important to them. Are they repeating what they have heard on social media, from friends, or other clinicians? Is the belief that they might have a chemical imbalance comforting, disturbing, or both? How does it affect the way they relate to their bodies and to the possibility of taking medication? The more you understand, the more you can address the "heart issues" that often underlie these beliefs.

Second, make sure clients are receiving proper medical care along with counseling. Sometimes, there are discoverable medical reasons for depression, such as hypothyroidism, and a medical or psychiatric evaluation will help identify and correct this issue.

Third, do not use biological explanations for depression as a way to decrease stigma. It is correct for counselors to seek to reduce shame and stigma associated with depression, but stating that depression is caused by faulty brain wiring or a chemical imbalance is not the way to do it. Our shame is not healed through biological explanations. It is healed in the truth that God knows and loves us as His beloved creatures, made in His image. No form of depression or any other mental illness can ever take that away.

Finally, treat your counselees as pilgrims and wayfarers, not as machines. Phrases like "chemical imbalance" and "brain disorder" encourage people to think of themselves as complex machines that are broken and need fixing… but humans are not machines. Instead, Scripture teaches us that we are *wayfarers*, pilgrims on a journey to God. The critical question for mental healthcare, then, is not "What is broken that needs to be fixed?" but rather, "What is needed, right now, for the journey?" Sometimes, what is needed is good counseling. Sometimes, what is needed is medication. Sometimes, what is needed is a close and supportive community. And sometimes, it is something else. However, it is always the *journey* that matters most.

WARREN KINGHORN, M.D., TH.D., *is a psychiatrist and theological ethicist at Duke University, co-director of the Theology, Medicine, and Culture Initiative at Duke Divinity School, and author of* Wayfaring: A Christian Approach to Mental Health Care *(Eerdmans, 2024).*

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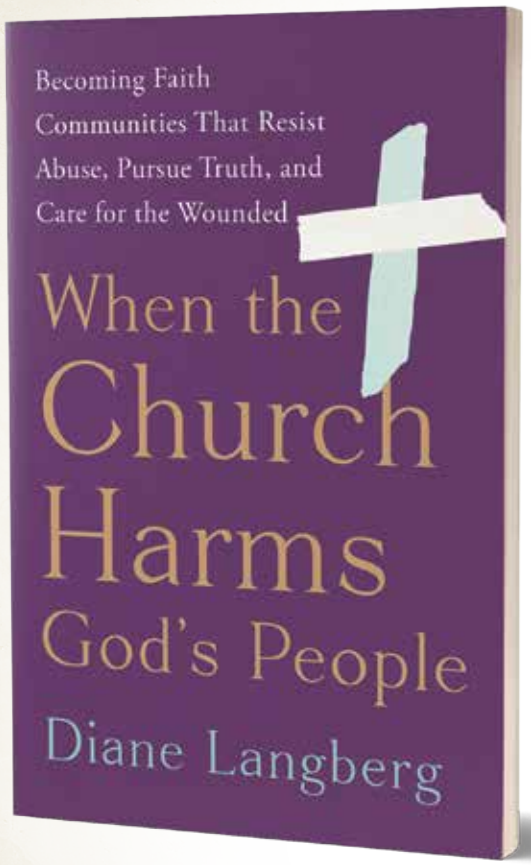

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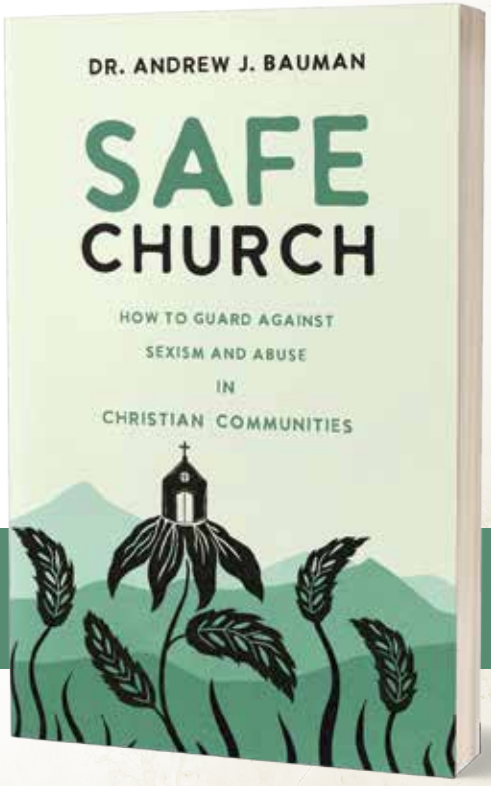

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THE NEUROSCIENCE OF DEPRESSION AND TODAY'S BEST THERAPIES

Clinical depression is more than just sadness or a series of bad days; it is a complex condition that affects millions of people worldwide, often manifesting in a range of symptoms from deep despair to persistent feelings of worthlessness. According to a recent poll, understanding depression is more critical now, as Americans are unhappier than ever.[1]

Each year, major depressive disorder affects an estimated 21 million American adults and nearly 3.7 million adolescents and teens, based on statistics from Mental Health America.[2] The rising rates of depression have led to a significant increase in antidepressant prescriptions—evidence that people are desperate for a solution. However, antidepressants do not always work. In fact, one study revealed that over half of patients with depression did not fully recover from their symptoms after using antidepressants. Even after four rounds of treatment, about one-third of depressed patients still had not achieved remission.[3]

This evidence signals that we need a better understanding of what depression is and better solutions to treat it more effectively—this is where neuroscience comes in. Neuroimaging shows us that depression is tied to both the structure and function of the brain. Fortunately, advances in functional brain imaging shed new light on depression and its causes, while breakthroughs in therapy offer new hope to those suffering.

Understanding the Depressed Brain

The human brain is the organ of emotion, decision-making, and self-regulation. When it is out of balance, so are we.

At Amen Clinics, we have spent decades using brain SPECT (single photon emission computed tomography) imaging to observe brain function in people struggling with depression. SPECT is a state-of-the-art brain imaging technology that measures blood flow and activity patterns. With 250,000 brain scans in our database, this work shows that depression is not a mental health problem but rather a brain health issue.

For example, when the limbic system—the brain's emotional center—is overactive, it is associated with feelings of sadness, negativity, and hopelessness. At the same time, underactivity in the prefrontal cortex, which governs decision-making and impulse control, can make it difficult for individuals with depression to break free from negative thought patterns.

Our brain-imaging work has also taught us that depression is not a single disorder; there are multiple types. Knowing your type is critical to getting the most effective treatment. In addition, depression is a symptom with many possible causes—ranging from head trauma and toxic exposure to inflammation and hormonal imbalances.

The Neurochemicals of Depression

In addition to the brain's limbic system, several neurochemicals influence moods, motivation, and depression. Think of these neurotransmitters as chemical messengers, communicating information between the brain and body. When neurotransmitters are balanced, people tend to feel more positive. When they are out of balance, it can let negativity and depression seep in.

In terms of depression, let's focus on four key neurotransmitters.

1. Dopamine: This neurotransmitter plays a crucial role in focus, staying on task, and memory. It helps the brain recall significant experiences, both positive and negative, and is involved in anticipation, pleasure, and feelings of love. Often referred to as the "chemical of more," dopamine drives the desire for more because it is central to the brain's reward system, making us feel good. Research has linked low levels of dopamine to depression.[4]

2. Serotonin: This chemical is linked to mood regulation, sleep, and adaptability, helping us remain open to changes. Serotonin levels rise when we feel respected by others and drop when our emotions are hurt. For decades, research has suggested a link between serotonin deficiency and depression. That is why some of the most common antidepressants—selective serotonin reuptake inhibitors (SSRIs)—work on serotonin receptors in the brain. However, more recent research is questioning the connection between low levels of serotonin and depression.[5]

3. Oxytocin: While dopamine is known as the "chemical of more," oxytocin could be called the "chemical of love" for its role in enhancing bonds and trust in relationships. It is released during physical closeness, such as cuddling, sexual activity, or social bonding. Low oxytocin levels have been linked to depression and a sense that our survival is being threatened.

DANIEL G. AMEN

4. Endorphins: Widely recognized as the "feel-good" chemicals, endorphins are released during physical activity, helping boost mood and promote well-being. They also enhance immune function by increasing immune cell circulation, protecting the body from illness. Importantly, endorphins also help manage pain. When endorphin levels dip too low, it has been associated with depressive disorder, anxiety, stress, mood swings, and more.

Breaking the Cycle of Depression

Understanding the brain patterns and neurochemicals associated with depression allows us to take a targeted approach to treatment. One of the most exciting breakthroughs in neuroscience is the discovery that the brain can change, known as neuroplasticity—the brain's ability to reorganize and form new neural connections throughout life. This means that even if depression has taken hold of your mind, change is possible with the right interventions. Finding ways to balance the brain and its neurotransmitters is vital to achieving lasting relief from depression.

In general, **exercise is one of the best brain and mental health activities**. Regular physical activity increases blood flow to the brain, stimulating the production of neurotransmitters like serotonin and dopamine, which enhance mood.

Evidence-based Therapies for Depression

Brain-targeted Supplements and Nutrition: According to a 2022 review in *Frontiers in Nutrition*, foods and supplements can play a critical role in optimizing brain function and mental health.[6] Psychiatrists are increasingly recognizing the importance of diet in depression treatment plans.

On the National Library of Medicine's PubMed.gov site, there are roughly 3,000 scientific abstracts on omega-3 fatty acids[7] and their effect on mood and nearly 5,000 abstracts on vitamin D and mood.[8] In particular, omega-3 fatty acids found in fish oil, vitamin D, and saffron have been shown to help balance mood and fight depression. Foods rich in antioxidants, such as blueberries and leafy greens, support overall brain health and protect it from oxidative stress, which is linked to depression.

Exercise: In general, exercise is one of the best brain and mental health activities. Regular physical activity increases blood flow to the brain, stimulating the production of neurotransmitters like serotonin and dopamine, which enhance mood. A 2023 study shows that engaging in physical activity is 1.5 times more effective at alleviating mild to moderate symptoms of depression, stress, and anxiety compared to medication or cognitive behavioral therapy.[9]

Psychotherapy and Cognitive Behavioral Therapy (CBT): Talk therapy, especially cognitive behavioral therapy, is effective in helping patients retrain their thoughts and develop healthier coping mechanisms. CBT helps individuals challenge and reframe negative thinking patterns, effectively reducing symptoms of depression.

Decades of research show that CBT is effective in reducing depressive symptoms.[10] Emerging brain-imaging studies also point to positive changes in brain function following CBT therapy.[11] This reinforces the understanding that the brain and mind both play roles in depression.

At Amen Clinics, we use a particular form of CBT called ANT therapy. ANT stands for automatic negative thoughts—the random thoughts that infest our minds and keep us mired in negativity. Learning to become aware of these ANTs and challenging them is one of the most powerful therapies for our patients who struggle with depression.

Bright Light Therapy: Depression can make us feel dark and gloomy, but research shows that looking at a bright light can brighten our mood.[12] Bright light therapy lamps increase serotonin levels and improve mood.

Prayer: The psychiatric field is beginning to acknowledge the importance of spirituality in mental health. For example, scientific research supports prayer as an effective therapy for depression and anxiety. In one study, participants who engaged in six, one-hour prayer sessions per week experienced a reduction in depression and anxiety.[13]

Other research findings suggest that praying daily and regularly attending religious services are associated with a host of health benefits, such as a lowered risk of depression, stress, addiction, and heart disease.[14] On the positive side, these spiritual activities are linked to increased happiness, longevity, and life satisfaction.

Brain Stimulation Therapies: For more severe cases of depression, treatments like transcranial magnetic stimulation (TMS) or even electroconvulsive therapy (ECT) may be necessary. These treatments work by stimulating areas of the brain that are underactive due to depression.

A Holistic Approach to Healing

In our clinics, we use the most effective, least toxic solutions for depression. This includes what we call the BRIGHT MINDS approach, which addresses 11 major risk factors that steal our minds and increase the risk of depression. By targeting these risk factors, from blood flow and inflammation to head trauma and toxins, we can help patients regain control over their mental health.

Depression is not a life sentence. With the right strategies, we can optimize our brains, break free from the cycle of negativity, and restore hope. It is time to rethink how we approach mental health and empower people to heal their brains and change their lives.

DANIEL G. AMEN, M.D., *is a physician, adult and child psychiatrist, and founder of Amen Clinics, which has the world's largest database of brain scans for psychiatry, totaling more than 250,000 SPECT scans on patients from 155 countries. He is the founder of BrainMD, a fast-growing, science-based nutraceutical company, and Amen University, which has trained thousands of medical and mental health professionals on the methods he has developed. A 12-time* New York Times *best-selling author, Dr. Amen's latest book,* Raising Mentally Strong Kids*, was released in 2024.*

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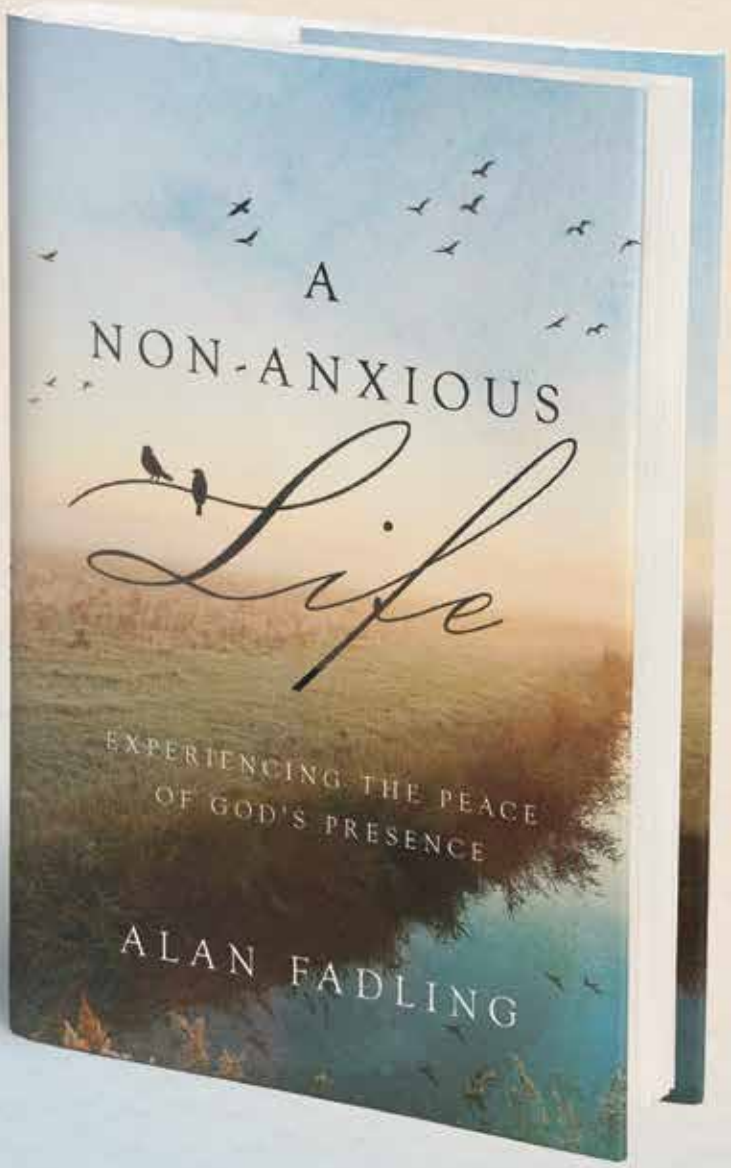
FINDING THE PATH TO PEACE

Is anxiety an unwelcome shadow over your days, bringing with it clenched teeth and an upset stomach? Alan Fadling brings counsel on how to learn a better way and who to look to for it: Jesus, "the ultimate non-anxious presence." Join Alan in releasing anxiety and taking up authentic love in A Non-Anxious Life.



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MANAGING AND ACHIEVING EFFECTIVE CARE FOR TREATMENT-RESISTANT DEPRESSION

From a Christian worldview, mental health, including depression, is approached holistically, considering the integration of mind, body, and spirit. Depression, including treatment-resistant depression (TRD), is a medical condition and involves biological, emotional, relational, and spiritual dimensions. Achieving effective care for TRD involves medical intervention, therapy, health and wellness measures, and spiritual care rooted in Christian values, such as hope, community support, and faith in God's purpose.

From a Christian perspective, depression is not a sign of weakness or lack of faith. It is a part of the human condition in a fallen world. The Bible acknowledges human suffering and sadness, exemplified by David in Psalm 34:18 (NIV): *"The Lord is close to the brokenhearted and saves those who are crushed in spirit."* God's presence is near those suffering from depression and offers hope and strength.

"There are several definitions and staging models of TRD and a consensus for each has not yet been established" (Voineskos et al., 2020, p. 221). The most common understanding is that TRD occurs when a person does not respond adequately to usual care with at least two different antidepressant treatments of sufficient dose and duration. People with TRD often experience more severe symptoms and longer episodes and may develop a sense of hopelessness due to the chronic nature of the condition.

Importantly, TRD does not mean the patient is resistant to treatment, but rather the depression is difficult to treat and inadequately responsive, resulting in chronic suffering. Suggesting the patient as resistant may stigmatize the patient and complicate treatment. Romans 8:28 (NIV) states, *"And we know that in all things God works for the good of those who love him…."* For Christians, even during suffering such as TRD, there is hope that God is working through their pain for a greater purpose, which can be a sustaining belief during challenging times.

Importantly, TRD does not mean the patient is resistant to treatment, but rather the depression is difficult to treat and inadequately responsive, resulting in chronic suffering.

Van Bronswijk et al., 2018, provided evidence for the inclusion of psychotherapy to improve outcomes for TRD. Psychological interventions for TRD include:

- Dialectical behavioral therapy (DBT)
- Cognitive behavioral therapy (CBT)
- The cognitive behavioral analysis system of psychotherapy (CBASP)
- Interpersonal therapy
- Mindfulness-based cognitive therapy

These interventions improve depressive symptoms, especially when combined with medication. Ijaz et al. (2018) reported, "We found that patients who receive psychotherapy as well as usual care with antidepressants had fewer depressive symptoms and were more often depression-free six months later compared with patients who continued with usual care alone" (p. 3).

Non-treatment-resistant depression refers to depressive episodes that respond to traditional treatments, including antidepressants, counseling, and psychotherapy. Symptoms may include sadness, lack of energy, loss of interest, inability to experience pleasure (anhedonia), impact on sleep and appetite, and difficulty concentrating, but they usually improve with proper treatment. Often, the improvement is not complete. For TRD, managing the condition requires more advanced treatments than standard depression care. All treatments can be understood within the Christian framework as necessary for restoring health and functioning in line with God's design for holistic well-being.

First-line pharmacologic treatment of depression most often begins with antidepressant medications that act in the brain at the synapse between neurons (nerve cells) communicating with each other. These medications block reuptake by pre-synaptic neurons involving monoamine transmitters, including serotonin, norepinephrine, and dopamine. Reuptake blockade increases the availability of these monoamines in the synapse to stimulate post-synaptic neurons to improve the transmission of messages for function. Selective serotonin reuptake inhibitors (SSRIs) include Fluoxetine (Prozac), Sertraline (Zoloft), Citalopram (Celexa), Escitalopram (Lexapro), Paroxetine (Paxil), and Fluvoxamine (Luvox). Serotonin-norepinephrine reuptake inhibitors (SNRIs) include Venlafaxine (Effexor XR), Desvenlafaxine (Pristiq), Duloxetine (Cymbalta), Milnacipran (Savella), and Levomilnacipran (Fetzima). Dopamine reuptake inhibitors (DRIs) include Bupropion (Wellbutrin).

Many patients require medication adjustments, which may include switching among the different classes of antidepressant medications. Another measure is augmenting existing antidepressants by adding Lithium, T3 (thyroid hormone), or second-generation antipsychotics (SGAs) such as Aripiprazole (Abilify), Quetiapine (Seroquel), Risperidone (Risperdal), Olanzapine (Zyprexa) (which is often combined with fluoxetine in the combination medication, Symbyax, for TRD), Lurasidone (Latuda) (which is approved for bipolar depression), and Ziprasidone (Geodon).

N-methyl-D-aspartate (NMDA) is a specific subtype of glutamate receptor in the brain that is crucial in synaptic plasticity, the ability of synapses to change in strength and efficiency in response to activity or experience. This process is fundamental to the brain's ability to learn, adapt, and store information, and it underlies many cognitive functions, including learning and memory. Auvelity combines Dextromethorphan (NMDA antagonism) and bupropion's dopaminergic effects. It reports a more rapid antidepressant response than traditional medications.

Ketamine and Esketamine primarily function as antagonists at the NMDA receptor, and by blocking this receptor, they reduce excitatory neurotransmission, which may contribute to their

anesthetic effects and rapid mood enhancement. They require supervised administration and may have some risk of misuse. Additionally, they may cause some patients to experience dissociation (feeling detached from reality). Ketamine and Esketamine increase levels of brain-derived neurotrophic factor (BDNF), a crucial protein in the brain that plays a significant role in neuronal health, growth, and function, with improved synaptic connections on mood and anxiety.

BDNF promotes neurogenesis, the growth of new neurons from neural stem cells, in the hippocampus, an area associated with mood, memory, and learning. The hippocampus shrinks with inflammation, chronic stress, depression, aging, lack of exercise, Alzheimer's disease, and substance abuse. Exercise and activities (even documented in ballroom dancing), social interaction, good sleep, healthy diet, cognitive training, meditation, mindfulness, stress reduction, and antidepressant medications maintain or increase the size of the hippocampus, supporting overall brain health and cognitive function.

Esketamine is the S-enantiomer derivative of ketamine. The United States Food and Drug Administration (FDA) approves it as a treatment for TRD, and it is usually administered as a nasal spray under the brand name Spravato. It is not a first-line treatment for depression, and it is typically reserved for people who have not found relief from traditional antidepressants or those in urgent need of treatment for suicidal thoughts.

Management of TRD often requires more advanced medical treatments, which can be understood within the Christian framework as necessary for restoring health and functioning in line with God's design for holistic well-being. Electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS) are options used when medication is insufficient. ECT involves applying electrical currents to the brain under anesthesia, while TMS uses magnetic fields to stimulate nerve cells. While some Christians are hesitant about such interventions, they can be embraced through scientific discovery as part of God's provision. Christian counseling can help individuals who are tentative about these more invasive treatments to process their concerns, offering spiritual encouragement and reminding them to trust that God's sovereignty also extends to medical interventions.

Competent Christian Counseling: Pursuing and Practicing Compassionate Soul Care, edited by Dr. Tim Clinton and George Ohlschlager, advocates for an approach to counseling grounded in biblical truth, compassion, and professional excellence. The key messages revolve around integrating faith with psychological best practices, caring for the whole person, empowering clients to take ownership of their healing journey, and relying on the Holy Spirit to guide the counselor and client through the healing process.

In summary, Christian counseling for treatment-resistant depression (TRD) integrates faith-based principles with psychological and therapeutic approaches to offer holistic support for individuals struggling with depression that has not responded to traditional treatments. This form of counseling emphasizes the spiritual dimension of healing, encouraging individuals to find hope, purpose, and meaning through their relationship with God, prayer, and Scripture while addressing emotional and psychological needs.

In Christian counseling for TRD, counselors may help individuals process their pain by considering Christian beliefs, exploring identity, forgiveness, and self-worth issues, and fostering resilience through faith-based practices. This approach complements medical treatments (like medication or therapy) and encourages reliance on God's guidance and strength through difficult times. It can offer comfort and hope, reminding those with TRD that their struggles can be met with grace, support, and spiritual renewal.

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Evidence-based Treatments *for* Confronting Depression

Among chronic diseases like diabetes, arthritis, angina, and asthma, major depressive disorder (MDD) contributes the most significant amount of disease burden and disability worldwide.[1] Even though antidepressant medication (ADM) is the most used treatment for depression, several major meta-analyses have revealed that this is not the best treatment strategy for various important reasons.

First, for mild depression, ADM therapy does not outperform a placebo. In fact, for mild depressive episodes, the American Psychiatric Association (APA) now recommends starting with evidence-based psychotherapies (EBP), such as cognitive behavioral therapy (CBT), behavioral activation (BA), and interpersonal therapy (IPT).[2]

Second, these same guidelines indicate that first-line treatment for moderate to severe depression should combine evidence-based psychotherapies with ADM therapy because the combination improves the chances of a more robust recovery better than either therapy alone.[3]

Third, in a more recent network meta-analysis involving 101 studies and more than 10,000 patients, cognitive therapy was just as effective as ADM, and combining the two produced a modest improvement of about 25%. An important finding was that evidence-based psychotherapy alone or in combination with ADM was more acceptable (i.e., patients were less likely to drop out of treatment) to patients than ADM by itself. The study's authors recommended that "… in routine clinical care it would be better to consider psychotherapy as the first choice when only one treatment is offered…."[4]

Fourth, for moderately to severely depressed patients treated to remission with either ADM or with CBT, after two years, those who were treated with CBT were much less likely to relapse (17.3%) than those receiving ADM (53.6%). This type of effect has been replicated in nearly all relevant clinical trials throughout the scientific literature.[5]

Evidence-based therapies delivered by well-trained providers are considered a solid choice for treating depression. The American Psychological Association's Division 12: Society of Clinical Psychology (SCP) identifies a list of 17 evidence-based treatments for depression that were rated modest to strong based on stringent research criteria (see div12.org/treatments/?_sfm_related_diagnosis=8149). Following, we briefly cover three treatments for depression, each rated as having strong evidence supporting their efficacy.[6]

Evidence-based therapies delivered by well-trained providers are considered a solid choice for treating depression.

Cognitive Behavioral Therapy (CBT)

For more than 60 years, psychiatrist Aaron Beck's cognitive theory has guided evidence-based research on understanding and treating psychological disorders. The basic premise of cognitive therapy is that there is a dynamic interconnection between our thoughts, feelings, and behaviors and that by focusing on changing thoughts and patterns of thinking, modifications in emotions and behaviors also occur. The cognitive therapy model of depression addresses how the early life experiences of those susceptible to depression can form negative core beliefs (referred to as schema) related to the worthlessness, inadequacy, incompetence, helplessness, and unlovability of the self and the unreliability and untrustworthiness of others. These schemas may lie dormant for years until they are activated by stressful life events, such as losing a loved one, a job loss, or marital conflicts.

Once activated, these core beliefs are maintained by information processing deficits, namely negative biases in attention and memory recall that selectively attend to information consistent with the negative core beliefs and systematically ignore anything that contradicts them. For example, a clinically depressed surgeon, married for 25 years with three happy, successful children in college and a wife who adores him, feels utterly incompetent and worthless after the family of one of his patients who died unexpectedly filed a malpractice lawsuit against him. All his personal failures and shortcomings dominated his mind, and he could not recall and appreciate his successes. When his family and friends pointed them out to him, he simply dismissed them as irrelevant or unimportant.

Cognitive therapy uses several cognitive and behavioral treatment strategies and skills to target these mental distortions and ultimately revise the underlying core beliefs. These include goal and agenda setting, daily mood log, activity scheduling, cognitive restructuring, problem-solving, and schema reconstruction. The treatment is considered short-term (eight to 16 sessions), with follow-up booster sessions to help protect against relapse. As noted, cognitive therapy performs better than medication for mild depression and is best when combined with medication for moderate to severe depression.

Behavioral Activation (BA)

The core premise of behavioral activation (BA) is that when people get depressed, they lose their energy, motivation, and anticipation for pleasure. As a result, they develop an avoidant pattern of behavior where they stop doing things that give them a sense of accomplishment, enjoyment, and social connectedness. This pattern only exacerbates their depressed mood and leads to more withdrawal and ruminative thinking patterns, where they disconnect from their environment and repetitively think about what is wrong with them and why they feel so badly.

The central focus of treatment is to reverse this pattern by helping clients identify activities and behaviors that reflect their underlying values about relationships, work, health, spirituality, and daily responsibilities. For example, with a depressed father who identifies being a good, loving dad as a core value, his therapist helped him identify specific behaviors that would reflect that value (e.g., throwing football with his children, attending practice, going fishing together) and then worked on scheduling that activity. Problem-solving skills are also used to overcome barriers and engage in positive, value-amplifying behaviors.

While cognitive therapy also uses behavioral activation strategies, the difference is that cognitive therapy uses the data generated by the behavior scheduling assignments to revise negative thinking patterns. In contrast, behavioral activation as a treatment does not directly challenge these thoughts. Nonetheless, behavioral activation does lead to changes in negative thoughts. Importantly, cognitive therapy tends to emphasize using behavioral activation techniques early in treatment, especially when depressive symptoms are more severe. When compared to cognitive therapy and ADM therapy, BA has been shown to be equally effective. It can help prevent relapse, although fewer studies have addressed its long-term effectiveness.

Interpersonal Psychotherapy (IPT)

Interpersonal Psychotherapy (IPT) conceptualizes depression as a medical illness that is triggered and maintained by primarily interpersonal factors that may be clustered into four categories.

1. Role transitions can be positive or negative life changes that are challenging because they require adjustments to new roles (e.g., having a baby, getting a new job, or being diagnosed with a chronic illness). Problem-solving skills are used to help clients adapt to the new challenges involved in the change.
2. Interpersonal disputes are relational conflicts that may trigger depression by themselves or result from role transitions. Communication analysis breaks down problematic communication patterns, and interactive role-plays teach more effective assertiveness and interpersonal problem-solving skills for repairing strained relationships.
3. Unresolved grief is frequently a trigger for depression. Various strategies are used to help facilitate the healthy, normal grief process, including encouraging the emotional expression of grief. Clients are also encouraged to explore and express their emotions (i.e., grief, anger, anxiety) as they relate to the role transitions and relationship problems.
4. Interpersonal deficits and loneliness are frequently a part of the depressive syndrome. They often arise in response to one of the first three stressors. For example, a client who became depressed after a miscarriage not only needed to resolve the loss but also address her tendency to withdraw from family and friends.

Therapy focuses on the most salient factors related to the client's depression. Then, it uses a variety of strategies to help address and resolve these problems, alleviating depressive symptoms and enhancing overall social-emotional functioning.

Like behavioral activation, IPT does not directly dispute cognitive distortions. For example, one client thought that others would perceive her negatively after she suffered a miscarriage, resulting in social isolation and withdrawal. The IPT therapist reframed this thought as being a part of the disease process of depression (medical model) and encouraged her to re-engage her friends as part of the homework.

IPT is also a short-term therapy that is typically delivered in 12-16 sessions and appears equally as effective as ADM for even severe depression. There is evidence that it can be used as a maintenance treatment for preventing relapse.

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DEPRESSION, HOPE, and SPIRITUAL WELL-BEING

During the COVID-19 pandemic, mental health issues in America rose at an alarming rate, with mental disorders increasing by 50%. However, one group alone in the first year of the pandemic showed improvements in mental health. Of the people who attended religious services, 46% reported “excellent” mental health compared to 42% the previous year (Rosmarin, 2021, p. 35).

How could this one group show improved mental health during a time of pandemic? Further investigation reveals that spiritual practices and experiences have a healing effect on stress and boost mental health (Miller et al., 2019). Participation in spiritual community activities such as church attendance, in particular, leads to healthier lifestyles, "… greater longevity, less depression and suicide, and less substance abuse. For many patients, spirituality is important and influences key outcomes in illness, such as quality of life and medical care decisions" (Balboni et al., 2022). Hope, faith, and overall spiritual well-being provide a source of strength and healing in the face of worldwide health threats and accompanying debilitating consequences such as depression and anxiety.

Depression

The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that more than 20 million Americans experience depression. SAMHSA identifies different types of depression, including major depressive disorder (MDD), persistent depressive disorder (PDD), postpartum depression (PPD), and psychotic depression. Depression has been linked to several possible causes, including genetic or biological, environmental, psychological, spiritual, and biochemical factors. In addition, trauma, major life changes, stress, anxiety, medication side effects, and some physical illnesses (e.g., diabetes or Parkinson's disease) have all been connected to increased depression (SAMHSA, n.d.).

A significant component of depression is the low mood and the accompanying negative thinking that can lead to self-harm and suicide. Interventions such as counseling and self-management education can help in controlling anxiety, depressed mood, poor dietary practices, and other symptoms connected to depression (National Institute of Mental Health, 2024). As the COVID-19 research discovered, however, spirituality and religious practices are powerful antidotes to the harmful effects of anxiety and depression. Faith and hope are essential to spiritual well-being, and they provide a therapeutic biblical response to the trials and tribulations by connecting us to Jehovah Rapha—the God who Heals.

The Essence of Spiritual Well-being

Spiritual well-being is anchored in love, faith, and hope, but we will focus primarily on the latter two components. *"Now faith is confidence in what (hypostasis) we hope for and assurance about what we do not see"* (Hebrews 11:1, NIV). "Faith is the basis, the substructure (*hypostasis* means literally 'that which stands under') of all that the Christian life means, all that the Christian hopes for" (Morris, 1981, p. 113). Faith has a personal aspect (having faith in Jesus), a past (what God has done in Christ), and also a future orientation. Our relationship with Christ provides access by faith into grace and favor with God, leading to joy, even in our suffering, because of our ultimate hope in Him.

> *"Through him we have also obtained access by faith into this grace in which we stand, and we rejoice in hope of the glory of God. Not only that, but we rejoice in our sufferings, knowing that suffering produces endurance, and endurance produces character, and character produces hope, and hope does not put us to shame, because God's love has been poured into our hearts through the Holy Spirit who has been given to us"* (Romans 5:2-5, ESV).

The presence of God is found in all areas of our lives and at all times. *"For I know the plans I have for you," declares the Lord, "plans to prosper you and not to harm you, plans to give you hope and a future"* (Jeremiah 29:11, NIV). Our response is to seek Him, acknowledge Him, and trust Him, particularly in our darkest times. *"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"* (Romans 15:13, NIV).

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Regardless of circumstances, no matter what happens, we need not fear or worry. Why? Because we have a guaranteed hope anchored in Christ and the promises of God, including our eternal security.

The Nature of Hope

The Greek word for hope, *elpis* (verb: *elpizō*), conveys both the act of hoping and the idea of the hoped-for object. Unlike the heathen Greek and Roman understanding, which viewed hope as simply anticipating various good or bad future events, biblical hope embraces a living expectation of something good and never the idea of nebulous or fearful expectation. "In many passages, *elpis* denotes not the personal attitude but the objective benefit of salvation toward which hope is directed" (thus Galatians 5:5; Colossians 1:5; Titus 2:13) (Hoffmann, 1976, p. 241).

There are three central features to biblical hope. The *content* of hope is always focused on God and Jesus Christ, never on self (*"For you have been my hope, Sovereign Lord, my confidence since my youth"* [Psalm 71:5, NIV]; *"Praise be to the God and Father of our Lord Jesus Christ! In his great mercy he has given us new birth into a living hope through the resurrection of Jesus Christ from the dead…"* [1 Peter 1:3, NIV]). The *basis* of hope is found in the grace of God in Jesus Christ, not in our personal efforts or good works (*"… Christ Jesus our hope…"* [1 Timothy 1:1, NIV]; *"… Christ in you, the hope of glory…"* [Colossians 1:27, NIV]). The *nature* of hope is a gift, a grace gift from God, full of eternal encouragement (*"May our Lord Jesus Christ himself and God our Father, who loved us and by his grace gave us eternal encouragement and good hope…"* [2 Thessalonians 2:16, NIV]; *"We were given this hope when we were saved…"* [Romans 8:24, NLT]). Hope is a function of a living faith, "… a confident, sure expectation of divine saving actions" (Hoffmann, 1976, pp. 242-243).

"We have this hope as an anchor for the soul, firm and secure. It enters the inner sanctuary behind the curtain, where our forerunner, Jesus, has entered on our behalf. He has become a high priest forever, in the order of Melchizedek" (Hebrews 6:19-20, NIV). Regardless of circumstances, no matter what happens, we need not fear or worry. Why? Because we have a guaranteed hope anchored in Christ and the promises of God, including our eternal security.

Hope, Trust, Anxiety, and Depression

Research in recent years has revealed the healthy benefits of a hopeful disposition in life. Hopeful people achieve more and are physically and psychologically healthier than less hopeful people (Snyder, 2000). Hope is a significant predictor of well-being and life satisfaction, and a protective factor against depression (Legacé-Séguin & d'Entremont, 2010; Singh et al., 2013; Oliver et al., 2016). A 2022 study has confirmed the relationship between hope, social support, spiritual coping, and depression, demonstrating the positive mediating effect of hope in alleviating depression and promoting social support and positive spiritual coping (Tao et al., 2022).

"Hope can decrease depression because depression is characterized by hopelessness. Hope can also provide confidence in oneself or in a sacred agent, which thus can mitigate anxiety. Spirituality—one's private experience of closeness or connection with the Sacred—can motivate people to let religion affect them. Both hope and forgiveness produce better relationships between ingroups and outgroups. Those improved relationships can in turn reduce stress" (Washington-Nortey et al., 2023, p. 372).

At a physical level, hope affects how we cope with pain. The central nervous system contains chemicals that can increase pain; however, hope interferes with the release of one of these chemicals, cholecystokinin (or CCK), "… thus allowing endorphins to be released as needed and relieve the pain" (Katsaros, 2013, p. 11).

The Focus of Our Hope

Underlying biblical hope is a trust in God (Romans 15:13), a confident expectation that God is in control in all situations and under all circumstances. "Only a confident expectation produces joy; wishing for something one is not sure to receive produces anxiety rather than joy. As Paul goes on to write, Christian hope is a hope that will never disappoint us (Romans 5:5)" (Mounce, 2006, pp. 340-341). *"Therefore, prepare your minds for action, keep sober in spirit, set your hope completely on the grace to be brought to you at the revelation of Jesus Christ"* (1 Peter 1:13, NASB).

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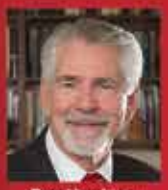
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EMERGING TRENDS, ISSUES, AND STRATEGIES FOR TREATING DEPRESSION

Depression has been considered for many decades to be the common cold of mental health disorders. However, this disorder can be complicated to cure with standard evidence-based strategies such as cognitive behavioral therapy (CBT). For those who suffer from these persistent depressive symptoms, it can be frustrating for the patient but also the clinician when what "should" work does not produce a significant amount of symptom reduction. It is at this point that clinicians need to get creative, think outside the box, and find new ways to treat or add new techniques or medication to the standard treatment to move the needle on this entrenched depression. Even though new research is being disseminated regularly, here are a few new strategies to determine what may be appropriate for your patients.

New Biological Treatments

Most clinicians working with someone who has persistent depression lean toward adding some type of medication to the patient's repertoire of therapy options. Unfortunately, many times, when medication is utilized, the patient can lose interest in learning techniques and skills that could produce more long-term results than just medication alone. It is essential for clinicians to be aware of this tendency and prepare patients for the limitations of medication alone as a "miracle" option.

One of the first points to recommend if the patient is open to medication is to have a complete physical. As we know, physical complications can masquerade as mental health challenges, and once these hormone levels, nutritional deficiencies, or even sleep issues are addressed, the depressive symptoms sometimes also evaporate.

A new option that has been both touted and demonized in the news lately for depression is the use of Ketamine or Esketamine. Ketamine started as an aesthetic in the 1960s but quickly moved to a street drug in the 1970s (https://www.delraycenter.com/a-brief-history-of-ketamine/). It was elevated to the status of a depression medication by the Food and Drug Administration (FDA) for both intravenous and intranasal avenues in 2019 (Agarkar, 2024). As you can imagine, it is important to be discerning about these types of medications as they have a history of being abused and can create dependency within the client or patient without proper oversight by a physician, usually in an inpatient situation.

Another unusual option that has been brought back from another time is electroconvulsive therapy (ECT), a medical procedure using a small electric current to prompt a brief seizure in the brain while the patient is under general anesthesia. It is still considered a very effective treatment for major depressive disorder (MDD), especially when the individual is also displaying suicidality or catatonia (Agarkar, 2024). There is an obvious stigma centered around this type of therapy due to news stories about its misuse, but it is still an effective therapy for MDD. Furthermore, ECT has now been utilized with success for those struggling with psychosis and bipolar depression; however, Ketamine is suggested as a first choice for treatment-resistant depression (TRD) at this time since ECT has displayed memory and cognitive issues after treatment.

The vagus nerve in the human body has received a great deal of attention due to its connection with trauma treatment. This nerve is connected to the brain and is part of the body's autonomic function, closely associated with individual emotional states. Vagus nerve stimulation (VNS) is a new treatment that has shown great promise and is similar to a pacemaker (Kavakbasi et al., 2024). The patient would have to undergo minor surgery to implant the device, stimulating the vagus nerve. So far, VNS has not had the same short-term results as ECT but has been showing more promising long-term results.

As we know, physical complications can masquerade as mental health challenges, and once these hormone levels, nutritional deficiencies, or even sleep issues are addressed, the depressive symptoms sometimes also evaporate.

MERCY CONNORS

New Psychological Methods

Radically open dialectical behavior therapy (RO DBT) is one of the "new kids on the block" for treating depression. Original dialectical behavior therapy (DBT) has been utilized quite effectively with borderline personality disorder (BPD) and bipolar I and II disorders. However, RO DBT has become a new option for people with treatment-resistant depression, which focuses on the patient's maladaptive overcontrol (Hatoum & Burton, 2024). This maladaptive overcontrol is linked to multiple symptoms often displayed in treatment-resistant depression, such as perfectionism, isolation, and difficulty with relationships. RO DBT follows the tenets of DBT but focuses explicitly on openness in multiple areas of a person's life. This is a highly manualized treatment with both individual and group sessions and has been found to work well with the overcontrol aspects of depression; however, it still needs further research on its full effectiveness.

Nature-based therapies have begun to be indicated as a possible add-on to therapy to help alleviate the symptoms of depression, stress, and anxiety (Paredes-Céspedes et al., 2024). One of these specific nature-based therapies that has become popular for depression is Forest Therapy (Wan, Wan, and Qiu, 2024). Forest Therapy utilizes nature to engage the five senses to help the mind and body regulate emotions psychologically and physically. It allows the forest to become a safe place for patients to engage with their thoughts about themselves, their past, and their future. Furthermore, Forest Therapy is designed to help individuals reduce their stress and become calmer. These aspects of Forest Therapy have increased its popularity as an add-on to what clinicians are already doing with patients to help improve depressive symptoms.

New Spiritual Methods

As faith-based clinicians or those who serve faith-based patients, we need to be prepared with some new spiritual techniques to help alleviate the persistent depressive symptoms that are derailing progress. One such example is adding to treatment a "40-Day Biblical Worldview Educational Treatment Program" (VanderWeerd, 2024). This addition to treatment helps individuals align their thoughts with the concepts of the Bible to live more authentically with their faith, which can reduce symptoms of depression and anxiety.

These new advances in the biological, psychological, and spiritual fields show us that there are more options available to those who are struggling with depression. Whether biological, psychological, or spiritual, clients and patients are multifaceted and comprise many aspects, meaning their treatment cannot be one-dimensional. Many of these treatment modalities can be added to what clinicians are already recommending to produce more significant and lasting change, which is the ultimate goal of our work.

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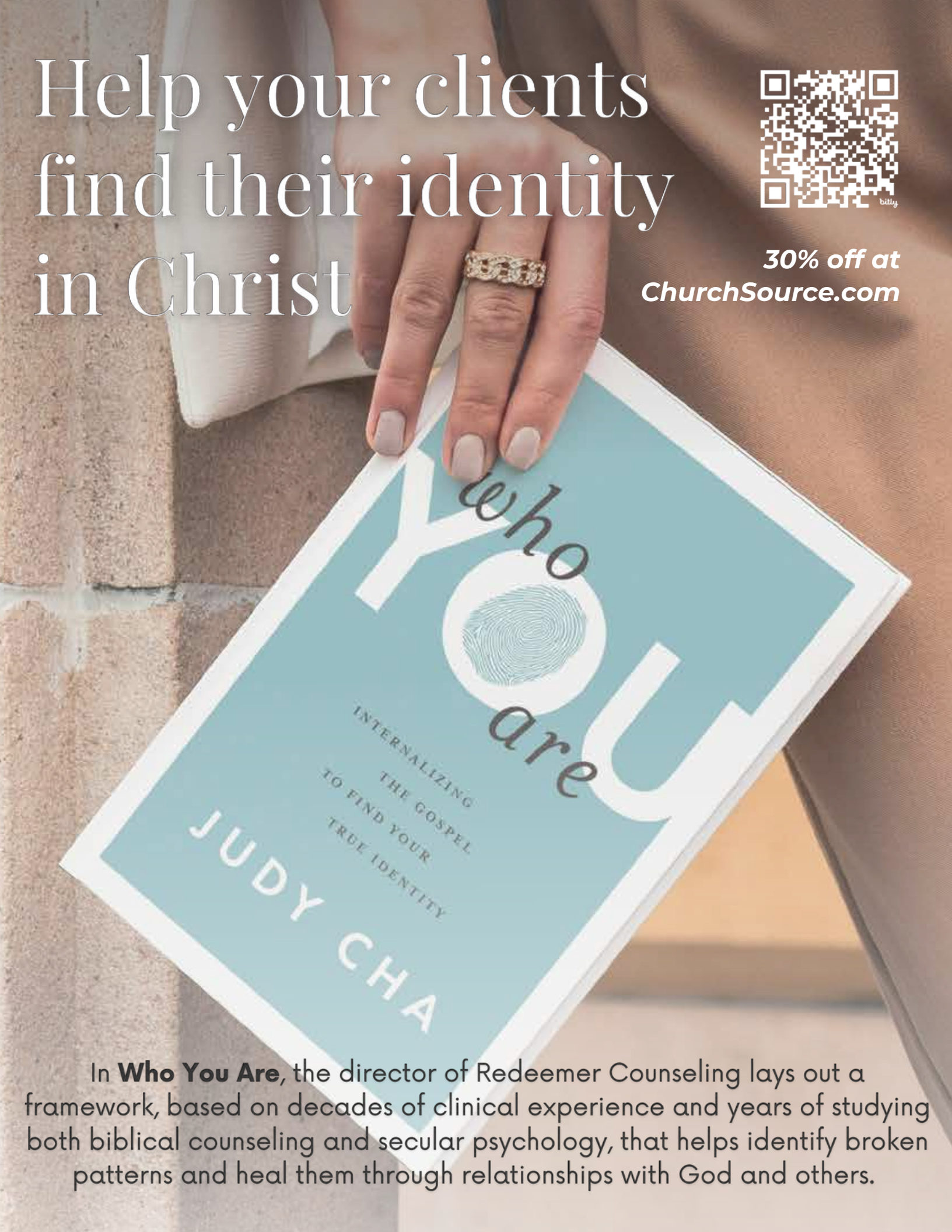

In **Who You Are**, the director of Redeemer Counseling lays out a framework, based on decades of clinical experience and years of studying both biblical counseling and secular psychology, that helps identify broken patterns and heal them through relationships with God and others.

RUMINATION, DESPAIR, AND SUICIDALITY:

Solutions for Lasting Change

Imagine this: It's the middle of the night, and you find yourself wide awake, staring at the ceiling. Despite your best efforts, your mind is flooded with thoughts—whirling, relentless, and heavy. Maybe it was that mistake you made last week or the sting of rejection from someone you trusted. No matter how hard you try, your brain will not quiet down. The thoughts loop endlessly, and with each replay, the emotions tied to them—shame, regret, hopelessness, fear—grow stronger. For many, these moments of mental overdrive are more than just frustrating; they are overwhelming. Left unchecked, the mind's ability to generate thoughts—some estimate up to 50,000 a day[1]—can feel like a prison.

For those stuck in this mental cycle, the constant rumination often spirals into something much darker. What started as an attempt to make sense of a difficult situation becomes emotional quicksand, pulling them deeper into despair. When the weight of these thoughts feels unbearable, some begin to wonder if there is a way out. Suicidal ideation quietly creeps in, offering what feels like an escape.

In today's world, with rising rates of mental health crises, we must confront the reality of this internal battle. Understanding how rumination and despair can fuel the darkest thoughts is critical to bringing hope and healing into the conversation. Let us begin this journey of exploring the roots of these struggles and, more importantly, discovering pathways toward wholeness.

In today's world, with rising rates of mental health crises, we must confront the reality of this internal battle. Understanding how rumination and despair can fuel the darkest thoughts is critical to bringing hope and healing into the conversation.

Rumination: A Dangerous Cycle

Rumination, as defined by mental health research, refers to repetitive and negative thinking focused on distressing experiences. This type of thinking does not lead to resolution but instead intensifies emotional pain and increases vulnerability to depression and anxiety, which can look similar to obsessive-compulsive disorder (OCD). When left unchecked, rumination can evolve into a dangerous mental state where despair and hopelessness take root.[2]

From a theological perspective, rumination can be seen as a form of inward focus that distracts us from God's promises of healing and renewal. The Bible encourages us to set our minds on things above, not earthly struggles (Colossians 3:2), which reminds us that shifting our focus from pain toward hope is vital to overcoming rumination. However, it is essential to acknowledge that simply "thinking positively" is not a sufficient response to deep emotional wounds. Instead, we must address the underlying causes of rumination, which often include unresolved trauma, unmet emotional needs, and maladaptive coping mechanisms.

MARK MAYFIELD



The Harmful Impact of Rumination

The experience of rumination often begins innocuously as an attempt to make sense of difficult emotions. Yet, when it becomes habitual, it fuels feelings of helplessness and hopelessness, feeding into a larger cycle of despair. Studies have shown that individuals who engage in rumination are at greater risk of developing mental health issues, such as depression and anxiety.[3] Furthermore, chronic rumination can distort one's sense of reality, leading individuals to believe their situation is far more dire than it may actually be. This distortion not only heightens emotional pain but also inhibits the ability to problem-solve effectively.

Emotionally, rumination keeps individuals locked in the past, revisiting moments of failure or rejection without moving forward. Psychologist, Susan Nolen-Hoeksema, explains that this pattern of thinking can become so entrenched that it takes on a life of its own, feeding into depressive symptoms and even suicidal ideation.[4]

Addressing rumination requires more than stopping the thoughts; it necessitates fostering emotional resilience, developing coping strategies, and engaging in practices that promote mental and spiritual well-being.

Despair: The Absence of Hope

As rumination progresses, it can often lead to despair, a state characterized by a profound loss of hope. Despair is more than sadness or grief—it is a deep sense of hopelessness where individuals believe their pain is permanent and unchangeable. This belief becomes self-reinforcing, creating a vicious cycle that isolates individuals from the relationships and resources that could bring healing.

Loneliness and isolation are significant contributors to despair. When individuals feel disconnected from others, they lose the relational support that could help them reframe their perspective and find hope. Loneliness is "the state of being unseen or unnoticed relationally, mentally, emotionally, physically, or spiritually. It can be driven by a lack of purpose, meaning, or relationship and is marked by a deep sense of hopelessness."[5]

Theologically, despair represents a spiritual separation from God's promises. In moments of despair, individuals struggle to believe that God has a plan for their lives or that His grace is sufficient to bring them through the darkness. Yet, Scripture reminds us that God's plans are for good, to give us a future and hope (Jeremiah 29:11). This assurance speaks directly to the heart of despair, offering a lifeline to those drowning in hopelessness.

One of the greatest dangers of despair is that it can lead individuals to perceive suicide as the only way out. Suicidal thoughts often arise when the pain feels unbearable and unending. The belief that nothing will change or get better becomes so intense that ending life seems like the only option for relief. In this space, interventions must be swift and compassionate, helping individuals see that hope is still attainable, though elusive at the moment.

Suicidality: A Call for Deep Healing

Suicidality is not a symptom that emerges in isolation—it is often the result of untreated or inadequately addressed emotional wounds. Suicidal ideation represents a desire to escape pain, and those who contemplate it frequently feel that no other options exist. However, the act of suicide is never a solution; it is a permanent response to what may be a temporary emotional state. Addressing suicidality requires that we intervene at the points of rumination and despair, offering holistic support that addresses the emotional, mental, spiritual, and relational dimensions of a person's pain.

One of the most powerful interventions for suicidality is fostering a sense of hope. Theologically, we know that God promises to never leave or forsake us, even in our darkest moments (Hebrews 13:5). Reaffirming this truth can be lifesaving, as it reminds individuals that their pain does not define their future and healing is possible. Providing practical support through counseling, pastoral care, and community engagement helps individuals feel connected to others and offers a sense of belonging that is critical for recovery.

Solutions for Lasting Change

Breaking the cycle of rumination, despair, and suicidality requires a holistic approach that encompasses the emotional, psychological, spiritual, and relational aspects of a person's life. The following are four key solutions that can foster lasting change:

1. Address the Root Causes of Rumination. It is essential to help individuals uncover the underlying causes of their rumination. Often, rumination is linked to unresolved trauma or unmet emotional needs. Psychotherapy, especially cognitive-behavioral therapy (CBT), can significantly identify and change the thought patterns that fuel rumination.[6] Moreover, providing spiritual guidance that emphasizes God's truth can help individuals shift their focus from the distortions of rumination to the hope and healing offered by faith.

2. Cultivate Emotional Intelligence and Resilience. Emotional intelligence (EI) is the ability to recognize, understand, and manage emotions. Developing EI is crucial in helping individuals navigate their emotions more effectively, preventing them from becoming trapped in rumination. Fathers, in particular, play a pivotal role in modeling emotional intelligence for their children, teaching them how to process emotions constructively.[7] By building emotional resilience, individuals can learn to cope with difficult emotions in healthier ways, reducing the risk of spiraling into despair.

3. Foster Supportive Relationships. Despair thrives in isolation, but healing occurs in community. Research consistently shows that individuals who feel connected to others are more resilient during emotional challenges. Encouraging individuals to engage in supportive relationships—whether through family, friends, church, or counseling—provides a buffer against despair and suicidality. As believers, we are called to bear one another's burdens (Galatians 6:2), creating a space where people can share their struggles without fear of judgment.

4. Reframe Suicidality with a Theology of Hope. The Christian faith offers a profound message of hope that transcends even the darkest moments of life. For individuals struggling with suicidal thoughts, it is essential to remind them that God's love and grace are greater than their pain (Romans 8:38-39). This does not mean offering simplistic solutions or dismissing their suffering but walking alongside them with empathy and compassion. The hope found in Christ's redemptive work assures us that, despite the troubles we face, He has overcome the world (John 16:33). God draws near to the brokenhearted (Psalm 34:18), offering rest to the weary (Matthew 11:28-30) and promises to strengthen and uphold those in their darkest moments (Isaiah 41:10). No situation is beyond God's ability to heal. As believers, we are called to offer the same comfort we have received from Him to those in need (2 Corinthians 1:3-4).

Conclusion

Rumination, despair, and suicidality are interconnected struggles that require a compassionate and comprehensive response. By addressing the root causes of rumination, fostering emotional intelligence, building supportive relationships, and offering a theology of hope, we can help individuals break free from the cycle of emotional pain and find lasting healing. As we engage in this work, we must remember that true healing comes from both practical support and God's unshakable hope. Nothing can separate us from the love of God (Romans 8:38-39), and in that love, there is always the promise of new life, even for those who feel trapped in despair.

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THE WHOLISTIC PARADIGM CHALLENGE WE FACE

Our highly industrialized society, with its technology backbone, requires us to rely on information from authority figures because it is simply not possible to know everything. Our failure as humans (and mental health professionals) is that we have primarily abdicated our right to think critically and question authority to verify motives and validate proffered statements of "fact." That we were trained to give up our inquisitive spirit from early childhood is how our profession arrived at the siloed, reductionist configuration in which we find ourselves.

What Does Our History Tell Us?

The wholistic treatment school is not a new form of medicine or mental health, nor is it a "new age" thing. Prior to 1915, wholistic was the dominant medical paradigm. In fact, a whole-body, mind, and spirit methodology to overall health, including mental health, goes back at least 2,000 years to the Greeks and likely farther. Treating the entire person as a wonderfully constructed compound vessel is not a new concept and has worked well for thousands of years.

Post-1915, "curing" a patient was replaced with a long-term pain management model. We have been taught to believe that the allopathic (MD), reductive approach is the only method that works, and any model that cannot be measured, proven, or turned into a pill is non-scientific and not to be trusted.

So why replace naturopathic and homeopathic treatment models with the reductionist pain management model? Because naturally occurring substances cannot be patented to bring in lots of money. It's that simple.

The Paradigm Challenge We Face

The task we face as a profession is convincing counselors that what we have been taught in school may not be the complete picture. In fact, it may not even be accurate, which is a tough red pill to swallow.

We are taught that the wholistic approach has no scientific basis, does not work, and that a good therapist will "stay in their lane," or our favorite phrase, our "scope of practice." We are told that our profession addresses the mind only and that any attempt to connect it with the body or, heaven forbid, the spirit is sheer quackery and is in the realm of other medical professionals. Then, we find ourselves wondering why the wealthiest, most advanced country in the history of the world has the unhealthiest population on the planet. Cognitive disconnect, anyone?

We must give ourselves permission to dust off our critical thinking skills, resume our natural curiosity, and question everything.

How Do We Implement a Wholistic Mindset in Our Practice?

The allopathic model is not all bad and gives us clues on how to proceed in employing a wholistic mental healthcare application. It is possible to easily build a practice model that specializes in your area of interest and treatment and is constructed on a "generalist" foundation of curative exploration.

Does it make sense that if we take a whole-person approach, our intake process must reflect that practice? Let's begin there.

KATHLEEN MILLS



If you can help a client with better food choices, pesticide-free water, uninterrupted sleep, and perhaps a little exercise and a reduction to harmful frequency exposure, is that not better than another pill or treatments they may not need?

The Five Basic Things

We all have five things in common as human beings: 1) a need for nutrient-dense food, 2) clean water, 3) restorative sleep, 4) some form of exercise, and, more recently, 5) a plan for dealing with the glut of electromagnetic field (EMF) radiation and 5G technology—the Five Basic Things. These are the basic building blocks, and a deficit in any one area will have a noticeable, genuine impact on a client's mental health. This is the first step for mental health professionals—making sure these Five Basic Things are addressed before beginning more advanced treatment options or prescribing additional pills.

I think counselors will find that an extremely high percentage of their clients are deficient in one or more of these areas and that bringing them "up to par" will have a very positive impact on their mental health. If you can help a client with better food choices, pesticide-free water, uninterrupted sleep, and perhaps a little exercise and a reduction to harmful frequency exposure, is that not better than another pill or treatments they may not need? This is where to begin.

Building on Your Foundational Work

Once these Five Basic Things are addressed, met, and ruled out as likely causes of any remaining issues, mental health professionals should proceed with additional assessments that will include any areas of specialization they offer.

Therapists' generalized body of knowledge should include a familiarity with the naturopathic approach, which aims to cure physical ailments rather than long-term pain management. There are certifications for this therapy and vast resources available on this topic. World-renowned naturopath, Dr. Peter Glidden, is fond of saying, "If we give the body what it needs, it will heal itself."[1]

A basic understanding of homeopathy's potential benefits is another form of natural treatment that counselors might employ in their assessment mindset and process. This discipline has existed since the early 1800s and is highly effective as a curative approach. Again, certifications and online assets abound.

Where Do We Go From Here?

I am *not* suggesting that clinicians become experts in all fields. That is not possible. However, I am proposing that they begin their client assessments with the Five Basic Things and do so in their intake process and first sessions. Then, acquire a competent familiarity with related fields to refer a patient to the most effective practitioner if they determine the client's issue to be outside their preferred scope of practice.

A wholistic, mind-body-spirit approach to mental health allows clinicians to view clients as the perfect creation God made them to be, help them identify their specific issues, and aid them in their restoration. Be *that* for your clients.

KATHLEEN MILLS, LPC-S, CEAP, CIMHP, *is a 34-year veteran of the counseling world. Based out of Frisco, Texas, she owns and operates a group practice, supervises and trains the next generation of counselors, and is the co-founder of two additional businesses, PracticeMentors.us and the Association for Mental Health Professionals (associationformentalhealthprofessionals.org), an alternative professional association for non-woke mental health professionals.*

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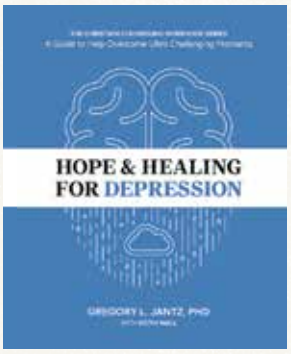

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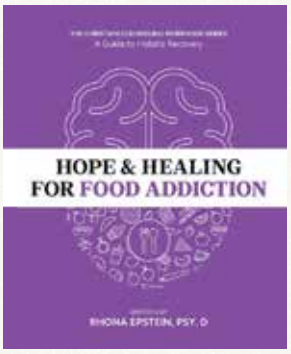

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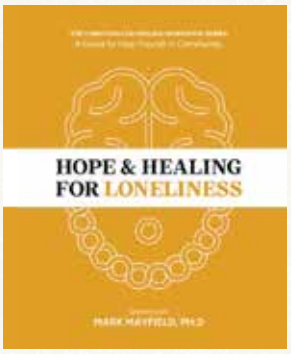

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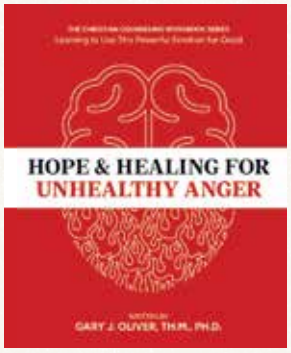

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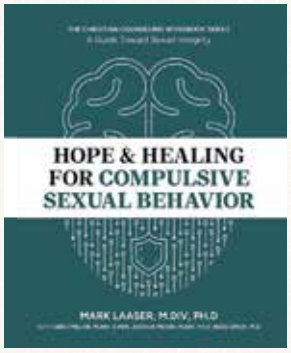

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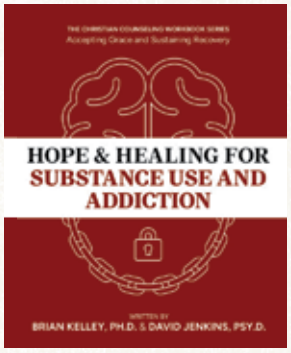

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The Right to Remain Silent

Do you have a difficult time turning off your mind at night? I do. My wife reminds me to turn it off every time she reaches over in bed and rests her hand on my shoulder. That is her way of saying, "You are tapping your fingers again on the headboard; let your mind rest. Turn it off!" Fidgeting is a telltale sign of my racing mind.

Not only does my restless mind rob me of sleep, but it also distracts my prayer life. Trying to pray in the morning is often cluttered with my schedule and to-do lists. While interceding for my family and church, my mind wanders, "I need to change out the air filters in our HVAC system, schedule a chiropractor appointment, and print out the staff meeting agenda."

It is hard to admit that our minds have limited capacity. We can only keep so much organized in these beautiful brains God gave us. Noise from the world adds to our clutter-ed minds. We are inundated with information, opinions, and outrage all day long. We are mentally and emotionally exhausted. As American Association of Christian Counselors President, Dr. Tim Clinton, says, "We are not facing a mental health crisis in our country, we are facing a mental health catastrophe."

When my mind and heart are restless, I like to take deep breaths and meditate on Psalm 46:10 (NIV): *"Be still, and know that I am God; I will be exalted among the nations, I will be exalted in the earth."* The following are four practical ways to be still and find rest for your mind and soul.

Save your words, time, energy, and emotional reserve for what matters most.

First, remain silent. You do not have to say everything you think. Proverbs 17:28 (NIV) says, *"Even fools are thought wise if they keep silent, and discerning if they hold their tongues."* Wisdom knows silence.

A friend of mine has a magnet on his refrigerator with a daily reminder from Mark Twain: "It is better to keep your mouth closed and let people think you are a fool than to open it and remove all doubt."[1] Restraining my words builds my emotional reserve. It leaves something in the tank. Silence refreshes my soul.

We all know someone who is constantly running their mouth. Their words are too much to take. They are always on edge, frantic, and joyless. When they come over for a visit, their words drain us. Proverbs 25:17 (NIV) says, *"Seldom set foot in your neighbor's house—too much of you, and they will hate you."* Don't let excessive word counts stay too long.

Second, practice online restraint. You do not have to post everything you think. Proverbs 18:2 (NIV) says, *"Fools find no pleasure in understanding but delight in airing their own opinions."*

Social media gives us a platform to share our opinions without sticking around for a conversation. We would never walk by two people having a conversation, blurt out our opinion, and keep walking. That would be rude. Yet, we do it all the time on Facebook, Instagram, and X.

Online restraint refreshes you and those around you. Yes, you need someone to share your pain, hurt, and frustration with; you just don't need to share it with everyone. Avoid throwing a pity party online, and never post when you are mad. Pass your posts and tweets by a reliable friend or family member first. Edit and delete when encouraged to do so.

Third, pick your battles. Every parent knows what I am talking about. You do not have the capacity, energy, or mind space to engage with every debate and discussion that comes your way. You have heard it said, "You don't have to show up to every fight you are invited to." Showing up to every fight leads to what some psychologists call "emotional flooding." When a person is emotionally flooded, focusing on the task in front of them is difficult because they are physically, emotionally, and mentally overwhelmed.

I have a pastor friend who recently removed all social media apps from his devices. He no longer posts or scrolls. When I asked him what led to this decision, he said, "I found myself preaching mad." When emotionally flooded, it is difficult to focus on the important task of studying and preaching.

The Bible calls us to pick our battles carefully in the Church. Paul instructed young Timothy to avoid battles that produce quarrels: *"Don't have anything to do with foolish and stupid arguments, because you know they produce quarrels. And the Lord's servant must not be quarrelsome but must be kind to everyone, able to teach, not resentful"* (2 Timothy 2:23-24, NIV). I like to remind my children, "Before you give someone a piece of your mind, consider your peace of mind." Don't waste your words or energy today on a frivolous debate.

Finally, focus on what matters most. God has a mission for you, and your work requires a great deal of focus and concentration. Restraining your words, limiting your time online, and picking your battles will free your heart and mind space for what matters most and keep you on the mission.

You are what psychologist and leadership coach, John Townsend, calls a "people helper." Your days are spent helping people work through complex issues of the soul, heart, and mind. You cannot afford to be distracted and drained, as you need plenty of energy to do what you do. Save your words, time, energy, and emotional reserve for what matters most.

When I pray with my wife and children, I end my prayers with, "Father, give them peace of heart and mind." I want those I love to walk in the freedom and joy that flows from a decluttered heart and mind. I would like that for you, too.

The Apostle Paul wrote about the mind that races with anxious thoughts and our need for prayer: *"Do not be anxious about anything, but in every situation, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus"* (Philippians 4:6-7, NIV). ✠

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Endnote

1 Twain, M. (n.d.). *A quote by Mark Twain*. Goodreads.

« SHANNAE ANDERSON, PH.D.

Haunted by a Restless Mind

Amelia was haunted by repeated intrusive memories of her son being shot. Although she was not present for the traumatic ending of her son's life, she constantly imagines those last terrifying moments. Strangely, she seems to cling to them despite their painful nature. Amelia suffers from post-traumatic stress disorder (PTSD) that tortures her with an agitated depression and a restless mind. Over and over, she replays the vision of what she believes her son experienced. The terror, helplessness, agony, and devastation of dying alone seem to trap her in a loop of what-ifs.

Trauma and the agitated depression that can accompany it often keep an individual hyper-focused on the event, re-creating the trauma over and over, trying somehow to undo the feelings of helplessness and powerlessness through the negative ruminations. To legitimize this phenomenon, the authors of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5-TR*) added two new symptoms to the official diagnosis of post-traumatic stress disorder in 2013. Within the diagnostic symptom profile that includes intrusions, avoidance, and hyperarousal, the authors included a persistent negative emotional state of mind and exaggerated negative beliefs to complete the syndrome definition. These pessimistic thoughts or expectations about oneself, others, or the world combine with distorted cognitions about the trauma's cause or consequences, leading to a relentless focus of blame on self or others. All of this occurs on the battlefield of the mind. In our depression and suffering, we seek to gain control over the uncontrollable and power over the powerlessness. If we can worry and hypermentalize, this may somehow make us feel better.

This agony of unremitting depression, combined with a restless mind, is echoed throughout the Bible. Job lost all his property and children and was rendered a broken man fighting a painful skin condition. To manage the acuity of his pain, he initially wept and grieved with his friends. They tore their robes and sprinkled dust on their heads, remaining silent together for a week. After that, Job ruminated aloud about his trials as he sought answers to why he was born and why God allows such sorrow. We know Job spent most of the book that bears his name battling with his friends about why he was chosen to endure such profound suffering. It isn't until the book's last few chapters

that Job humbles himself and seeks the Lord's perspective on his trials and pain.

Likewise, we know David was tormented by pain and depression, as evidenced in the Psalms. David battled depression due to his guilt and shame over his sin with Bathsheba, as well as devastation over losing his son and being hunted by King Saul. For example, in Psalm 13:1-2 (NKJV), David repeats the question "how long" four times to the Lord as he struggles with issues about his fate:

"How long, O Lord? Will You forget me forever?

How long will You hide Your face from me?

How long shall I take counsel in my soul,

Having sorrow in my heart daily?

How long will my enemy be exalted over me?"

His mind is clearly ruminating over what he cannot control. Yet, at the end of the Psalm, he capitulates in verse 5, *"But I have trusted in Your mercy; My heart shall rejoice in Your salvation."* Despite being plagued by unanswered whys, David chooses to trust God at His word and rests in His mercy and salvation.

Even Jesus was tormented in the Garden of Gethsemane the night before His crucifixion. We know from Mark 14:34 that Jesus told His three close disciples to pray for Him as, *"… My soul is exceedingly sorrowful, even to death…."* Jesus was agonizing about His impending arrest, torture, and crucifixion. He was so distraught that He even sweated blood as His flesh contemplated all He would endure. Although Jesus was obedient unto death, His humanness was battling.

While all these individuals struggled differently with suffering from a restless mind, each ultimately found comfort and solace in the Lord. Unfortunately, instead of reaching out to God, we often spiral in our minds, seeking to understand and make sense of why we feel as we do, as if gaining insight somehow lessens the pain. We often seek to find someone to blame for our pain, as if finding justice somehow eases the pain. We frequently criticize and condemn ourselves for our pain, as if self-blame somehow lessens the pain. None of these distractions ultimately diminishes our suffering. In fact, the only answer is to cry out to God. Seeking to understand breeds a restless mind, and seeking God brings us peace.

Seeking to understand breeds a restless mind, and seeking God brings us peace.

We need to trust the One who sees all, who knows all. Remember Matthew 10:29-31 (ESV): *"Are not two sparrows sold for a penny? And not one of them will fall to the ground apart from your Father. But even the hairs of your head are all numbered. Fear not, therefore; you are of more value than many sparrows."* God is omniscient and knows all. He is also love and loves us endlessly and beyond what we can imagine. We need to let God carry our burdens, our trauma, our depression, our pain. He knows the whys of the world and the whys of our pain. Knowing our limited capabilities, He usually protects us from those answers. What He gives us instead is His peace.

The opposite of a restless mind is the *peace that surpasses all understanding* (Philippians 4:7). However, how do we find God's peace amid the voices in our heads and the sorrow in our hearts? We must meditate on God's Word to find His peace. For example, Psalm 119:15 (NASB) says, *"I will meditate on Your precepts And regard Your ways."* When we focus on the precepts of God and respect His ways, our thoughts will be rerouted from our distress to the presence of the Lord Almighty. His ways lead us to Him. We know from Psalm 34:17-18 (ESV), *"When the righteous cry for help, the LORD hears and delivers them out of all their troubles. The LORD is near to the brokenhearted and saves the crushed in spirit."* This verse reassures us that God is close to us in our pain and is ready to deliver us; we need to cry out to Him for His comfort.

Little children run to their parents for comfort when distressed. They do not hypothesize about the whys of the situation. They do not ruminate over who is to blame or how they will tolerate the pain. They seek the love and reassurance from their parents that they cannot give themselves. Similarly, when we are stuck in a depressive state with a restless mind, we, too, need to become like little children who run to our Heavenly Father for solace. As a small child cannot comprehend the intricacies of the situation, neither can we understand the complexities of life… but God can. He seeks for us to run to Him and rest in Him. May you find the peace you seek in the Lord. ✠

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« GARY W. MOON, M.DIV., PH.D.

Learning the 3-Rs of Earth School: Recognizing, Responding, and Reflecting

I was driving through the streets of a large city early one morning when an advertisement on the radio grabbed my attention. The exuberant voice of a young pastor announced, "Come on out to our revival services this weekend. We have a special worship leader who can really lead you into the presence of God."

I recall my next thought from more than three decades ago as if it were yesterday. *"Wouldn't it be much bigger news if any person on the planet had the power to lead you out of the presence of God? After all, I reasoned, isn't God already everywhere, omnipresent? Is it not in God that we live and move and have our being?"*[1]

Now, I knew what the pastor intended to communicate. Or, at least, I was prepared to give him the benefit of the doubt. This revival would feature a time of music each night with the hope that the instrumentation, lyrics, and inspirational suggestions would inspire those in the audience to become more *aware* of the reality of God's presence and love. To worship. But, even so, that moment still burns in my memory. It occurred shortly after a special encounter that caused me to begin thinking about the first "R" (Recognition) of what I have started to see as the "3-Rs" of Christian spiritual formation.

In the years that have followed, I have come to believe that the best things we can do with our time in earth school are to learn to better: 1) *Recognize* the loving presence of the Trinity, 2) *Respond* in kind to this personal and loving presence, and

3) *Reflect* on these miraculous interactions and how each can change our lives, and the lives of those around us, in the direction of love.

Recognition

A few years before that radio advert, I had begun to think more seriously about how one can learn to hear better—to recognize God's voice. This was primarily the result of listening to an inspired talk by the charismatic Baptist pastor, Peter Lord. The occasion was a small conference he had built around the theme of learning how to better "hear" the voice of God and distinguish it from that of the "thief and robber." I had never before (nor have I since) discovered a more helpful teaching on the subject of practical discernment.

Let me simply share four of Peter Lord's thoughts that I continue to use almost daily.[2] Whenever I become conscious of words playing through the speaker system of my thought-life, and I wonder whether what I am experiencing is coming from "channel 1" (Peter Lord called this station, WGOD) or "channel 2", WSIN, I pause and ask myself one or more of the following questions:

1. Did that thought seem more in line with the gentle voice of a shepherd or the loud, pushy, intrusive noise of a cattle driver?
2. Is this thought taking me deeper into the present moment, or is it taking me away from the present to either past regrets or future fears or dreams?
3. Does the thought suggest how the relationship could improve if someone else became a better person (an external solution) or how I might become a better person (an internal solution)? God does not triangulate.
4. However, the best advice offered was by far the most simple and straightforward. What was the emotional impact of the communication? Did I feel more love, peace, and joy, or were my emotions the opposite of these three spiritual fruits—anger, anxiety, and discouragement?

Now, as a psychologist, I am well aware that there is a third channel broadcasting in my head—often 24/7. I call that channel WSLF. WSLF is the stream of thoughts that amounts to a hit parade from the best, but more often worst, of all the voices I have heard through the years from my parents, teachers, friends, etc. This channel, channel 3, if you will, also plays in my head, but it is a bit easier to sort out. Typically, WSLF offers a very familiar playlist. Most of the time, I can identify its source and tell you when those words first began playing inside my mental jukebox.

However, when it comes to recognizing melodies and the contrasting cacophonies from the other two stations, WGOD and WSIN, all I can say is, "Thank you, Peter Lord." I still remember your words and use them often. I am also thankful to good cognitive psychology for helping me with "channel 3."

Respond

Even when we correctly identify the source of the mental music as coming from WGOD, there is still a crucial second step to take. How should I respond to the voice?

Fortunately, Scripture provides a host of examples. For this brief column, I will again limit myself to four examples, each of which is a classic and exemplary response.

From the prophets Elijah and Samuel, we learn that the voice of God is most often found not in the roar of mountain-tearing winds, the thunder of earth-shaking tremors, or destructive fires but in a still, small voice. Thank you, Elijah (see 1 Kings 19:11-13, NKJV). And we learn Samuel's most foundational response to this quiet and deep whisper: *"Speak, for your servant is listening"* (see 1 Samuel 3:10, NIV).

From a young Jewish girl hearing God's voice through the mouth of an angel and facing the threat of unspeakable humiliation and ostracism, we learn the response she made for herself and every future vessel of the Lord. She said, *"… I am the Lord's servant, let everything you've said happen to me"* (see Luke 1:38; GW).

Finally, Jesus provides the ultimate model for how to respond to the voice of His and our Father. In Gethsemane, He steps back into a garden to set right what had gone so terribly wrong in a prior garden. There, even in the face of unspeakable pain and suffering, He models two perfect responses—transparency and willingness. Jesus does not deny the pain. He says with great authenticity: *"… Father, if it's possible, let this cup of suffering be taken away from me."* Then, He also models the radical trust and willingness that Adam and Eve got so wrong. He says, *"But let your will be done rather than mine"* (see Matthew 26:39b; GW).

Reflection

I have a dear friend from South Africa who I am beginning to quote almost as much as Dallas Willard. His name is Trevor Hudson, and he likes to remind his listeners that change, real change, does not happen through recognition and response alone. Nor does it happen through simply taking in more information or feeling more inspiration.

If our discipleship efforts are to become a real apprenticeship to Jesus, we must move beyond simply

accumulating more facts and information about Him. We can all look into a mirror and confess the following truth. Even though a person knows a lot about the life and teachings of Jesus and has a ton of head knowledge, it is possible, as we all know, to fail dismally to reflect His other-centered love and compassion.[3]

And we know deep inside that we must also move beyond seeking to be continuously inspired by alpine peaks of experience. As Trevor often and poignantly warns, the relentless pursuit of inspirational highs usually leads toward the deadly pitfalls of consumer religion. Inspiration alone does not transform.[4]

So, if not more information and inspiration, what does work? What does produce real change? The disciples of the first century of church history, and today, need real interaction with the Trinity. Here and now. We must experience, reflect, and reflect again on these special interactions with the invisible real. And when our interactions seem to match those we read about in Scripture and those of the devotion masters, the patriarchs and matriarchs of the Church who appear through the pages of church history, we can then be sure that real change is happening. However, just to be safe, we should ask those closest to us if they have noticed a change.

Conclusion

Jesus' number one teaching point was the present availability of the Kingdom of God. Paul's was Christ in me and you, the hope of glory and transformation. These two teaching points may sound different, but they are identical. The first is the *goal*: recognizing and responding to the Kingdom, here and now. The second is the *methodology*: saying a thousand "yeses" each day to the great mystery of being in Christ.

Jesus' number one teaching point happens through will realignment. Paul's number one teaching point is about the methodology for how this can happen. When we recognize and respond to this great offer of Jesus—and then reflect on what is happening—we are on the healing journey back home to union with God. It is a journey of recognition, responding, and reflecting. And it requires a little information and inspiration but a whole lot of interaction. ✠

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Endnotes

1 See Acts 17:28.

2 While Peter Lord is no longer living, I was not surprised that the content of this retreat was later published as a book titled, *Hearing God*. The original edition was published by Baker Publishing in 1988.

3 See *Seeking God: Finding another kind of life with St. Ignatius and Dallas Willard*. (2022). NavPress. See also Trevor's online teaching on this book: https://conversatio.org/collections/another-kind-of-life/.

4 *Seeking God: Finding another kind of life with St. Ignatius and Dallas Willard.* (2022). See, in particular, chapter 5, "Exploring life's greatest opportunity."

When we recognize and respond to this great offer of Jesus—and then reflect on what is happening—we are on the healing journey back home to union with God. It is a journey of recognition, responding, and reflecting.

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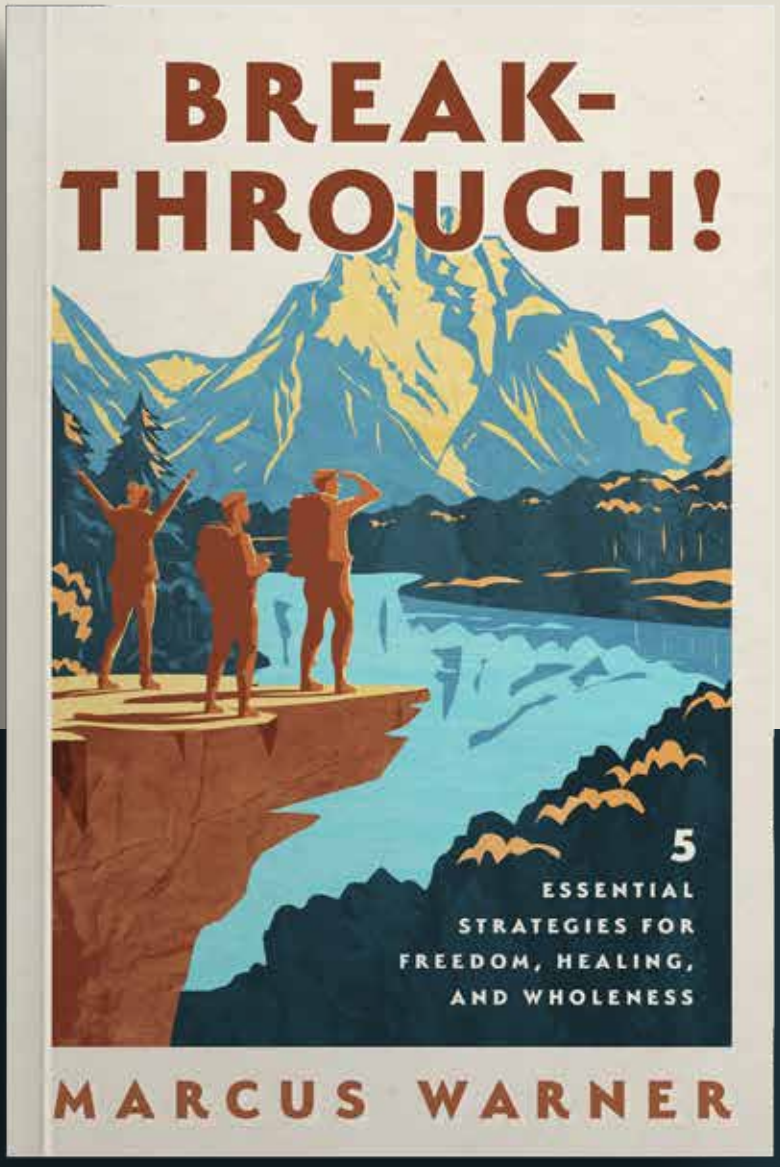

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« MICHAEL R. LYLES, M.D.

Praying Better for the Sick: A Physician's Recommendations

Praying for the sick is a foundational Christian practice. Faith-based practitioners often discuss whether to pray with patients in person or private. However, the question of what to pray for is seldom discussed. This results in many generic "get better" prayers that lack specificity to the patient's needs and circumstances.

As a physician who has walked with physically and mentally ill patients for more than four decades, I believe that all of us must learn to "pray better" with more specificity. Many common themes in illness would benefit from loving and believing prayer support. The following are my physician recommendations for what we can intentionally pray for concerning sick patients.

• **Encouragement.** Healing is often a long journey. Pray for little victories that encourage the patient to persevere for another day. The little victory may be a symptom improvement or an act of kindness by someone who puts a smile on the patient's face for that day. Pray for new encouragements every day (Lamentations 3:22-26).

• **Expectations.** People get better in little steps over time that are not linear. There may be good days that alternate with difficult ones. They may get worse before they get better. Pray for clear expectations about what the path of healing will look like and the hope to see the process through to completion (Psalm 27:13-14; 69:3; 37:23, 24).

• **Acceptance.** Pray that the patient will understand and accept their diagnosis and treatment recommendations. Even when it is difficult and may not seem to work, pray for compliance with the treatment plan. Pray that they will not focus on why they are suffering but on how to respond differently (Philippians 4:11-13).

• **Grace and Forgiveness.** Some illnesses may result from poor life choices or failure at self-care. This can promote internal shame and broken relationships with loved ones. Pray that the patient will be given forgiveness and grace to regain lost trust. A focus on blame seldom promotes the healing of relationships needed for long-term health and recovery (Matthew 6:12-15; Psalm 51:10-12).

• **Waiting (Patience).** Much of help-seeking involves waiting. Waiting to see the doctor. Waiting for test results to come in. Waiting for treatment to work or fail. Waiting to see if side effects, relapses, or complications will occur. Pray for a timely diagnostic and treatment process. Waiting alone is significantly worse, so pray for support from people who will stand beside the patient through the difficult "waits." Loneliness is a potential complication of all illnesses. Playing board games, cards, chess, going for a walk together, reading or discussing a book together, or praying together at an appointed time can be substantial "treatments" for lonely waiting (Job 14:14; Psalm 130:6; Isaiah 40:28-31; Jeremiah 14:22).

• **Active Advocacy.** Pray that the patient will understand how to actively participate in their care instead of being a passive victim. They will need accurate educational resources and protection against online misinformation. Pray for someone on their treatment team (not just the doctor) to take an interest in the patient and answer their questions. Also, pray that the patient will receive clear direction on how they can help the treatment team facilitate a healing outcome (Ecclesiastes 4:9-12; John 5:6-9).

• **"Getting Better" Prayers.** These prayers usually focus on a symptom that is totally going away. However, "getting better" may involve resolving some, but not all, symptoms. It will often take time to achieve whatever level of "getting better" is attained. Pray that the consequences of an acute illness episode are limited after the patient gets better. For chronic illnesses, pray that the long-term progression, impact of the sickness, and required treatment are limited. Patients may need help handling suffering that may remain even after the patient experiences some improvement (Psalm 73:26; Romans 8:28).

• **"HOW" Attitude.** Pray that the patient will be **H**ONEST with their questions and reports about their situation with their treatment team. Pray that the patient will be **O**PEN to receiving help—and that the needed help is available. Pray that the patient will be **W**ILLING to follow the treatment recommendations even if they do not fully understand or agree (Psalm 32:3-7; 139:23-24).

• **Provider Issues.** Pray that the provider will see the patient as a person, not a diagnosis, procedure, or insurance type. Also, pray that the provider will find some way to connect with the patient and their family. It may be a sports team, hobby, hometown, faith, or common acquaintances. I referred my cousin to a new internist who went to college several blocks from where he grew up. I thought they might connect over their shared familiarity with the neighborhood. Unfortunately, he discovered that the doctor despised the school and neighborhood. However, they both criticized the same issues in the neighborhood and bonded over their perspective. Now, they lament together during office visits. Patients need to be "seen" (Genesis 16:13; Psalm 139:1-4, 17).

• **The Necessities of Life.** Pray for the patient and family to receive help with meals, transportation, grocery shopping, yardwork, childcare, laundry, and housework. This type of help can be a game-changer (James 1:27; 2:14-17).

• **Spiritual Attitude.** When someone is sick, it takes vision to see a healing result. It requires courage to persevere in the face of worries of bad outcomes. Spiritual and emotional challenges—such as fear, discouragement, anger, grief, and defeat—are common. Pray for the patient to experience "hands-on" spiritual support from their community of faith (Psalm 34:17-19; Romans 15:1-3, 13-14; Philippians 4:14).

The potentially overwhelming uncertainty of how illness and treatment will transpire can be counterbalanced by the certainty of supportive people who act as the hands, feet, mouth, and ears of God in the patient's life. Pray for a few people who will visit, call, FaceTime, and pray with the patient. The assurance of human love and concern can refocus the patient on gratitude about what is working well in their life in the face of suffering (Job 13:15; Habakkuk 3:17-19; John 13:35; 15:12-13).

When patients are suffering in the valley of illness, they need to be lifted to a higher rock of healing than they can reach alone (Psalm 61:1-3). Thoughtful, passionate, and specific prayer, combined with loving action, is a convincing tool to access the power of God—the ultimate source of healing (James 5:14-16). ✠

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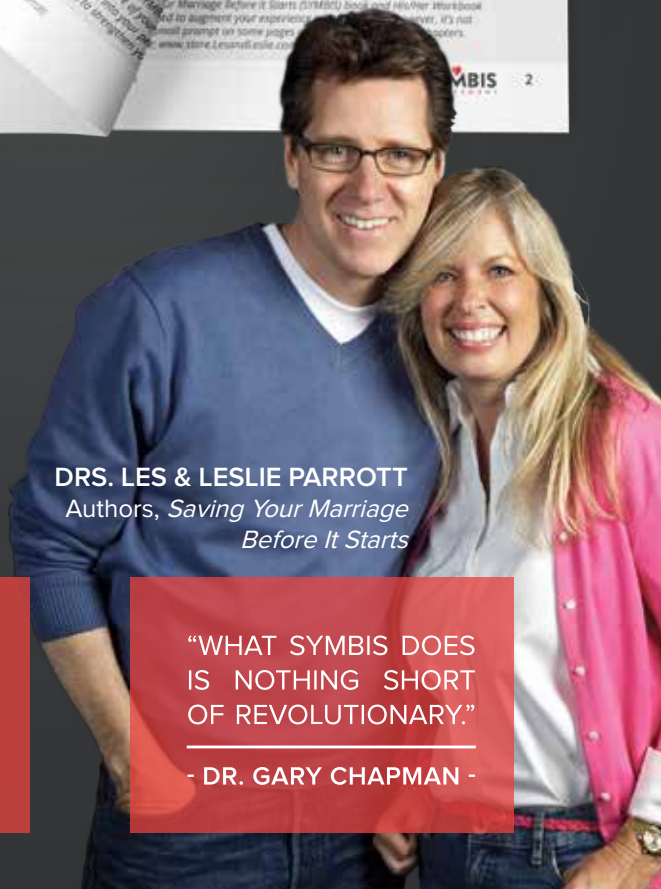

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« JEANNEANE MAXON, J.D., ESQ.

Impact of the ACA's Recent Action Alert on Laws Restricting Gender-affirming Care for Minors

The American Counseling Association (ACA) recently issued an "action alert" addressing a wave of state-level legislative actions that regulate gender-affirming care for minors, linking to a page on its website encouraging its members to "Take Action."[1] This comes in response to a growing number of states that are recognizing medical, emotional, and psychological harm involved in a minor transitioning from one biological sex to another gender. The alert also impacts the rights of professional counselors and therapists, particularly regarding the right of conscience to refuse to provide such "treatment" when it conflicts with their moral or religious beliefs.

The Dangers of Gender Transitioning for Minors

Reputable organizations have recognized numerous dangers in providing gender transitioning to minors, including but not limited to:

- Puberty blockers can negatively affect bone growth and density, especially when administered early in puberty,[2] and prolonged use can result in reduced bone mineral density that may not fully recover even with subsequent hormone therapy.[3] Additionally, the use of puberty blockers puts children in a state of "developmental limbo," potentially impeding psychological maturation and social development.[4]
- Hormone Replacement Therapy (HRT) can increase the risk of cardiovascular

A critical aspect of the debate surrounding SOCE laws concerns the right of healthcare professionals to refuse to provide such care based on moral or religious objections.

issues, such as hypertension and thromboembolic events. Estrogen therapy, in particular, can lead to elevated triglyceride levels, increased risk of blood clots, and changes in bone density, particularly when started at an early age.[5] What is more, neuroimaging studies suggest that cross-sex hormones can alter brain structure and functional connectivity. In the case of testosterone therapy, it has been shown to affect cognitive processes related to visuospatial functioning, a domain that typically shows sex differences in performance. This raises concerns that hormone therapy may alter the neurocognitive development of adolescents.[6]

- Surgical interventions for minors, including mastectomies (for transgender males) and facial feminization surgeries (for transgender females), carry significant medical risks. For example, mastectomies performed on minors can result in nerve damage and loss of sensation, which may have long-term impacts on body image and sexual function.[7] Additionally, decisions made during adolescence may not align with individuals' long-term identities or satisfaction with their bodies.[8] Moreover, there is a notable rate of regret reported among those who undergo irreversible surgeries. However, the incidence varies across studies and is influenced by factors such as age at the time of surgery and levels of support and counseling.[9] In fact, in July of 2023, several individuals who expressed regret that they underwent gender transitioning testified before Congress. Among the statements they reported were:
  - "The adults in my life, whom I trusted, affirmed my belief (that I was misgendered), and this caused me lifelong, irreversible harm."
  - The interventions were based on "coercion," according to one trans-gendering victim, who said one specialist she consulted threatened her parents by asking, "Would you rather have a dead daughter or a living transgender son?"
  - "At 16, after my surgery, I did become suicidal… my parents almost got the dead daughter promised to them by my doctors. "My doctors had almost created the very nightmare they said they were trying to avoid."[10]

State-action to Protect Minors and Counselors

As of 2024, 21 states[11] and Washington, D.C., have enacted laws to prohibit Sexual Orientation Change Efforts (SOCE), also known as conversion therapy, for minors. These laws have withstood legal challenges and may potentially be brought before the U.S. Supreme Court in the future.

Several federal courts have upheld state laws that prohibit SOCE, or conversion therapy, for minors. The two prominent cases include *Pickup v. Brown* (9th Circuit, 2014) and *King v. Governor of New Jersey* (3rd Circuit, 2014).

Additionally, district courts in Arkansas, Alabama, Florida, Georgia, Indiana, Kentucky, and Tennessee have blocked similar bans on gender-affirming care for minors, citing violations of constitutional rights, including the Equal Protection and Due Process Clauses.[12]

The Need for Conscience Protections for Professional Counselors

A critical aspect of the debate surrounding SOCE laws concerns the right of healthcare professionals to refuse to provide such care based on moral or religious objections. The ACA's action alert acknowledges the growing pressure on counselors and mental health professionals to align with state mandates or face legal repercussions. This has sparked a broader discussion on the need for explicit conscience protections for counselors, particularly in states with broad gender-affirming care mandates.

The right of conscience has been historically recognized in cases involving abortion and end-of-life care,[13] where healthcare professionals are legally protected from being compelled to participate. However, conscience rights for counselors in the context of gender-affirming care are less clearly defined, leading to ambiguity and professional uncertainty.

Some states, like Tennessee and Mississippi, have already passed laws that explicitly protect counselors from being forced to provide services that conflict with their beliefs (Tennessee Senate Bill 1556, 2016; Mississippi House Bill 1523, 2016). These laws, known as "conscience clauses," allow counselors to refer clients to other professionals without fear of legal or professional penalties.

What Can You Do to Protect Your Right of Conscience?

Regardless of whether your state is protecting your right of conscience, it is essential to tactfully assert your right of conscience when faced with any situation where clients request you to participate in an activity that goes against your sincerely held religious and moral beliefs. In such a situation, it is wise to do a "values-based referral."[14] Be sure to keep the interests of your client(s) in mind by ensuring any transition of care occurs smoothly and at an appropriate time.

If you are not already involved in your state's counseling association and voicing your opinion, consider doing so. Already, the counseling association in at least one state (Texas) has responded to the action alert by issuing a statement to its members saying that it supports "gender-affirming care" and noting its objection to laws that would protect counselors and minors from the dangerous practice of gender transitioning.

The information contained in this column is provided for educational purposes only. Nothing in this column should be construed as legal advice, and readers should seek advice from a qualified attorney within their jurisdiction for concerns/questions on specific matters. The law varies from jurisdiction to jurisdiction.

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14 A values-based referral is where one refers to another counselor based on one's conscience and not ability.

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Uplifting the Playing Field

"Finally, brothers and sisters, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable—if anything is excellent or praiseworthy—think about such things." – Philippians 4:8, NIV

This issue of *CCT* focuses on the causes and consequences of clinical depression. As leaders, we experience the impacts of depression but can feel powerless over many of those causes and consequences, which happen in places beyond our control. So, what can we control? We can control our "playing field," where we have more effect than we realize.

We often talk about creating a balanced environment for the benefit of those around us; we say we want to *level the playing field*. I would like to suggest that, as leaders, we need to do more and *uplift the playing field*. And what is our "playing field?" It is the environment we create and maintain for ourselves and those who work with and for us.

The previous verse from Philippians can seem to run counter to today's fast-paced, stress-filled work and leadership environment. It seems we are being asked to produce more with less, from resources to workers. We find ourselves scrambling to stretch what we have to produce what we need. In that pressure

cooker environment, our thinking can too easily turn to the faulty, the frustrating, the failures—all the roadblocks and obstacles to getting done what is needed. When roadblocks take on human faces, we turn our co-workers, our allies, into adversaries, producing a playing field of toxic negativity. We can become a corporate Bobby Knight, an infamous university basketball head coach known for vicious tirades against other teams, coaches, officials, and even his own players. Did he win championships? Yes, but at what cost?

According to a 2022 Gallup report titled, "The Economic Cost of Poor Employee Mental Health," the study found the following, "Projected over a 12-month period, workers with fair or poor mental health are estimated to have nearly 12 days of unplanned absences annually compared with 2.5 days for all other workers. Generalized across the U.S. workforce, this missed work is estimated to cost the economy $47.6 billion annually in lost productivity."[1]

Employee mental health challenges, such as depression, come at a cost. They drain already stretched resources. While work is work and people's private lives are their own, leaders, however, can contribute some protective factors for those they serve. In a divisive, critical, and tear-down culture, leaders can choose to focus on the excellent and praiseworthy and not just notice but share and communicate. Leaders can intentionally make a goal to compliment, applaud, and commend the good things people do, large and small.

Dr. Rick Hanson is credited with saying, "The human brain is like Velcro for negative experiences and Teflon for positive ones."[2] Given this, I have heard everywhere about the need for a 10-to-1 to a 3-to-1 ratio of positives to counter a negative. As a leader, what is your ratio for those who work with and for you? How often do you criticize, and how frequently do you commend?

A 2021 study published in *Brain Science*, titled "Biological, Psychological and Social Determinants of Depression: A Review of Recent Literature," condensed the findings on depression from 470 diverse studies. Now, as a leader, you have no control over an individual's biological depression determinants. However, after reading this study, I was struck by how leaders could have a positive effect on psychological determinants. Under the psychological factors listed as determinants in this study were conditions such as negative self-concept, sensitivity to rejection, and negative emotionality. Personal characteristics, such as shame and low self-esteem, were also included. How well do you know those who work with and for you? Are you as adept at understanding and reacting to your workers' needs as you are to, say, your clients, customers, or benefactors?

There is no one-size-fits-all worker, and not all workers are carbon copies of the most productive. Studies have shown certain demographics are more at risk for depression. The Gallup study I previously mentioned reported, "Struggles with mental health are not evenly distributed across the working population. As with other mental health indicators—including depression—women (23%) are more likely to report poor or fair mental health than are men (15%). Nearly one-third of young workers under the age of 30 (31%) do the same compared with 11% of those aged 50-64 and 9% of those aged 65 and over. As such, working women under the age of 30 carry the greatest burden of fair or poor mental health (36%) across all age-by-gender subgroups."[3] Understanding which workers might have a higher vulnerability to depressive tendencies can help you

identify those who may need additional assistance, reassurance, and encouragement, especially in stressful, demanding, and difficult work situations. Coming alongside is your challenge—and your privilege—as a leader.

Proverbs 16:24 (NIV) says: *"Gracious words are a honeycomb, sweet to the soul and healing to the bones."* Proverbs 3:27 (NIV) says: *"Do not withhold good from those to whom it is due, when it is in your power to act."* Ephesians 4:29 (CJB) says: *"Let no harmful language come from your mouth, only good words that are helpful in meeting the need, words that will benefit those who hear them."* As leaders, we have the power to heal and the power to harm; we have the power to act and the power to withhold. As we seek to *uplift the playing field*, I encourage all of us to intentionally focus on and prioritize the positive and to know and be alert to the needs of those we serve. Then, in a small way, we can act as protective factors in a too-often complex and oppressive world. ✠

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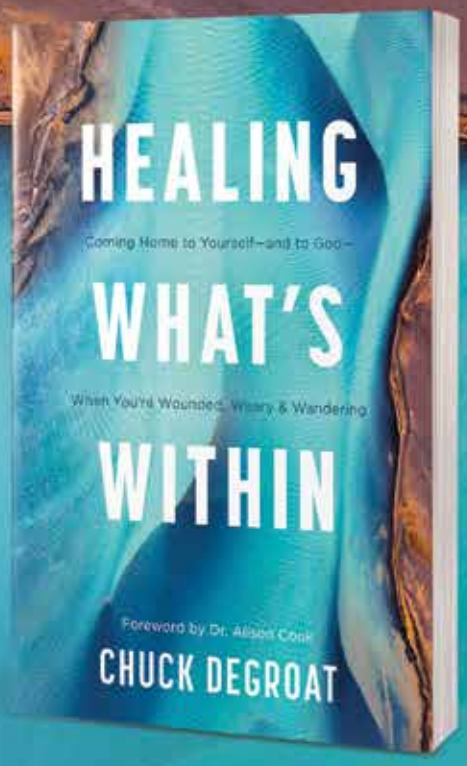

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Cutting-edge Treatments for Depression

Most Christian clinicians know about cognitive behavioral therapy (CBT) for depression, but research has explored many treatments for this condition and even CBT in non-traditional formats. This Research Digest will examine several treatments with a variety of populations.

Effects of Intensive Short-term Dynamic Psychotherapy on Treatment-resistant Depression

Heshmati, R., Wienicke, F.J., & Driessen, E. (2023). The effects of intensive short-term dynamic psychotherapy on depressive symptoms, negative affect, and emotional repression in single treatment-resistant depression: A randomized controlled trial. *Psychotherapy, 60*(4), 497-511.

Intensive short-term dynamic psychotherapy (ISTDP) theorizes that treatment-resistant depression (TRD) comes from hidden emotions that are repressed or avoided due to attachment-related trauma. People use a variety of defense mechanisms that maintain this repression. Heshmati and colleagues wanted to investigate whether ISTDP demonstrably reduced negative repressed affect (supporting ISTDP's theory) and lowered depression symptoms in a sample of 86 adults diagnosed with TRD (defined in the study as major depression unresponsive to at least one round of antidepressants).

The researchers randomized participants into 20-session ISTDP and waiting-list control groups. Findings supported that ISTDP reduced emotional repression, negative affect, and depression symptoms both at the end of treatment and in a three-month follow-up. Effect sizes for all these improvements were large, lending credence to ISTDP's theory and efficacy as a depression treatment. Further studies are warranted.

The results of this study and other research on ISTDP are informative for Christian therapists since depressed Christian clients can use a variety of defense mechanisms, such as spiritual bypass, to avoid addressing repressed negative affect. ISTDP and sound Christian psychological themes may be useful components for addressing TRD in Christian clients.

Interventional Approaches to Treatment-resistant Depression in Children and Adolescents

Faries, E., Mabe, L.A., Franzen, R.L., et al. (2024). Interventional approaches to treatment-resistant depression (TRD) in children and adolescents: A systematic review and meta-analysis. *Journal of Affective Disorders, 367*, 519-529.

Depression rates are rising for adolescents. Faries' research team meta-analyzed studies on repetitive transcranial magnetic stimulation (rTMS), electroconvulsive therapy (ECT), and ketamine as interventions for treatment-resistant depression (TRD) in this population. TRD was conceptualized as a failure to respond to standard treatments like selective serotonin reuptake inhibitors (SSRIs) and psychotherapy.

Ten studies with 711 adolescents met the criteria for the researchers' analysis. Five studies focused on ECT, three on rTMS, and two on ketamine. Results indicated that

Regarding outcomes, rTMS was the most effective compared to ECT and ketamine, although ECT and ketamine also provided substantial symptom relief.

each treatment (ECT, rTMS, and ketamine) led to significant depression symptom reductions. Regarding outcomes, rTMS was the most effective compared to ECT and ketamine, although ECT and ketamine also provided substantial symptom relief. Long-term data suggested that rTMS showed superior long-term outcomes and a better side effect profile. The authors cautioned, however, against over-interpreting the superiority of rTMS and encouraged further studies to compare these treatments against each other directly. Nevertheless, the authors suggested that the noninvasive nature of rTMS and its favorable side effects make it a potential first-line therapy for TRD in youth.

Christian clinicians may field many questions from parents about these three approaches to TRD. Ketamine generates a need for careful theological exploration and consultation with the literature (well beyond this Research Digest) regarding its potential usage and some reported adverse events. ECT and rTMS, likewise, require careful theological consideration. For example, the fall impacts our biology, and these treatments try to address TRD physiologically (as antidepressants do). Christians can differ on the appropriateness of each of these strategies. Thus, the reviewed article only gives a limited idea of current empirical evidence for these approaches and does not take on other important considerations. Further studies and Christian integration literature should be consulted.

Comparing Cognitive Behavioral Therapy Interventions Among Latin American University Students

Benjet, C., Albor, Y., Alvis-Barranco, L., et al. (2023). Internet-delivered cognitive behavior therapy versus treatment as usual for anxiety and depression among Latin American university students: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 91*(12), 694-707.

Low- and middle-income countries (LMICs) have challenges in addressing depression and anxiety disorders in part because of the limited availability of traditional mental health services. Scalable, low-cost solutions, therefore, could increase access to evidence-based treatments. Benjet and colleagues investigated two different modalities of delivering Internet-based culturally-adapted CBT (i-CBT) and treatment as usual (TAU) in Mexico and Colombia with 1,319 total university students.

The students were randomized into three different groups. Guided i-CBT used standard CBT methods and included text or other message-based support and personalized feedback from a trainer with at least an undergraduate degree in psychology. The second group consisted of self-guided i-CBT. The researchers theorized that the additional support in guided i-CBT would improve accountability, enhance treatment adherence, and decrease dropout compared to the self-guided version. The third group involved treatment as usual based on whatever the specific university provided for student mental health needs. Measurements took place at randomization and three months later.

The guided i-CBT group reflected higher remission of depression and anxiety and greater mean differences from pre-treatment to three months later compared to both of the other groups. The self-guided i-CBT results were comparable to those of TAU, which may be meaningful since the costs of TAU are substantially higher than those of an Internet-based program. However, universities varied widely in the mental health services offered, so caution should be used when interpreting this finding. Overall, the results for guided i-CBT were very encouraging because of its potential scalability in addressing important mental health needs in underserved areas internationally. The researchers recognized the study's limitations and the need for further research to confirm their findings. For Christian therapists, the results indirectly highlight the potential for Internet-based Christian integrative CBT services.

Final Thoughts

This Research Digest highlighted several lesser-known treatments for TRD (e.g., ISTDP and rTMS) and some that need further theological consideration beyond the scope of this article (e.g., ketamine). It also considered the needs of adolescents and the Latin American population. Guided i-CBT programs may be able to increase access to evidence-based treatments. In all these areas, Christian therapists are called to respond with the love and wisdom of Christ in serving their neighbors. ✠

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Answer the following questions from this issue of Christian Counseling Today by marking the appropriate circle. Once completed, you may send in this entire page or a photocopy with your payment to the address below. Please do not send cash. The quiz is open-book and you will need a minimum score of 70% to receive a letter of completion.

Beyond the Broken Brain: Why Depression is Not (Only)… – Warren Kinghorn

1. The author contends that in most cases depression is
   - O a. genetic in nature
   - O b. caused by a chemical imbalance in the brain
   - O c. a response to deep social and relational challenges
   - O d. a medical disorder such as hypothyroidism

Emerging Trends, Issues, and Strategies for Treating Depression – Mercy Connors

2. Which of the following therapies has a stigma around it
   - O a. Forest Therapy
   - O b. Electroconvulsive therapy (ECT)
   - O c. Ketamine
   - O d. Vagus nerve treatment

Evidence-based Treatments for Confronting Depression – Gary A. Sibcy, II and Jonathan Norman

3. Which of the following is **NOT** true regarding treatment
   - O a. using antidepressant medication (ADM) vs. cognitive behavioral therapy (CBT) shows ADM clients were less likely to relapse
   - O b. for mild depression, ADM does not outperform a placebo
   - O c. schemata are core beliefs from early life experiences
   - O d. behavioral activation (BA) therapy does not challenge thoughts

Haunted by a Restless Mind – Shannae Anderson

4. Instead of reaching out to God in suffering we often
   - O a. criticize and condemn ourselves
   - O b. try to gain insight to lessen pain
   - O c. seek to find someone to blame
   - O d. all of the above

Managing and Achieving Effective Care… – E. John Kuhnley

5. Treatment-resistant Depression (TRD) occurs when a person does not respond adequately to
   - O a. spiritual counseling efforts
   - O b. at least two different antidepressant treatments
   - O c. cognitive behavioral therapy (CBT) or interpersonal therapy
   - O d. electroconvulsive therapy (ECT)

An Overview of Clinical Depression: What We Know… – Gregory L. Jantz

6. The National Institute of Mental Health (NIMH) reports the two most prevalent types of depression are
   - O a. major depression and bipolar disorder
   - O b. dysthymia and major depression
   - O c. bipolar disorder and perinatal depression
   - O d. major depression and depression with psychotic features

Learning the 3-Rs of Earth School: Recognizing, Responding, and Reflecting – Gary W. Moon

7. Biblical examples of the **Respond** aspect in this article
   - O a. Elijah, Samuel, Mary, and Jesus
   - O b. David, Paul, Elijah, and Samuel
   - O c. Elijah, Samuel, Peter, and David
   - O d. Samuel, Mary, Paul, and Jesus

Rumination, Despair, and Suicidality: Solutions for Lasting Change – Mark Mayfield

8. Which of the following is **NOT** true of rumination
   - O a. may be caused by unresolved trauma
   - O b. is characterized by repetitive negative thinking
   - O c. can be resolved by thinking positively
   - O d. can evolve into a dangerous mental state

The Neuroscience of Depression and Today's Best Therapies – Daniel G. Amen

9. The Amen Clinics use a form of cognitive behavioral therapy (CBT) called
   - O a. misbelief therapy
   - O b. automatic negative thoughts (ANT)
   - O c. brain SPECT (single photon emission computed tomography) imaging
   - O d. all of the above

The Wholistic Paradigm Challenge We Face – Kathleen Mills

10. The author believes that
    - O a. ruling out the Five Basic Things should precede treatment
    - O b. we have abdicated our right to think critically
    - O c. curing a patient has been replaced by pain management
    - O d. all of the above

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Dr. Tim Clinton
President, American Association of Christian Counselors

Introducing the all-new **Mental Health Coach Certification Program**—a 42-hour, biblically-based training that consists of three courses. Enroll and successfully complete all three courses and become a "Certified Mental Health Coach" by the International Board of Christian Care.

Our initial goal in 2021 was to engage 750 churches and train 7,500 Mental Health First Responders in and through these congregations. We had no idea what was going to happen but God did! Over 17,000 churches and 50,000 students are now enrolled. Get started now!

Who can enroll? Under the discretion of your church, **anyone with a calling to offer help, hope, and encouragement** to those who are hurting and looking for guidance and direction in everyday life.

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Ron Hawkins, D.Min., Ed.D.


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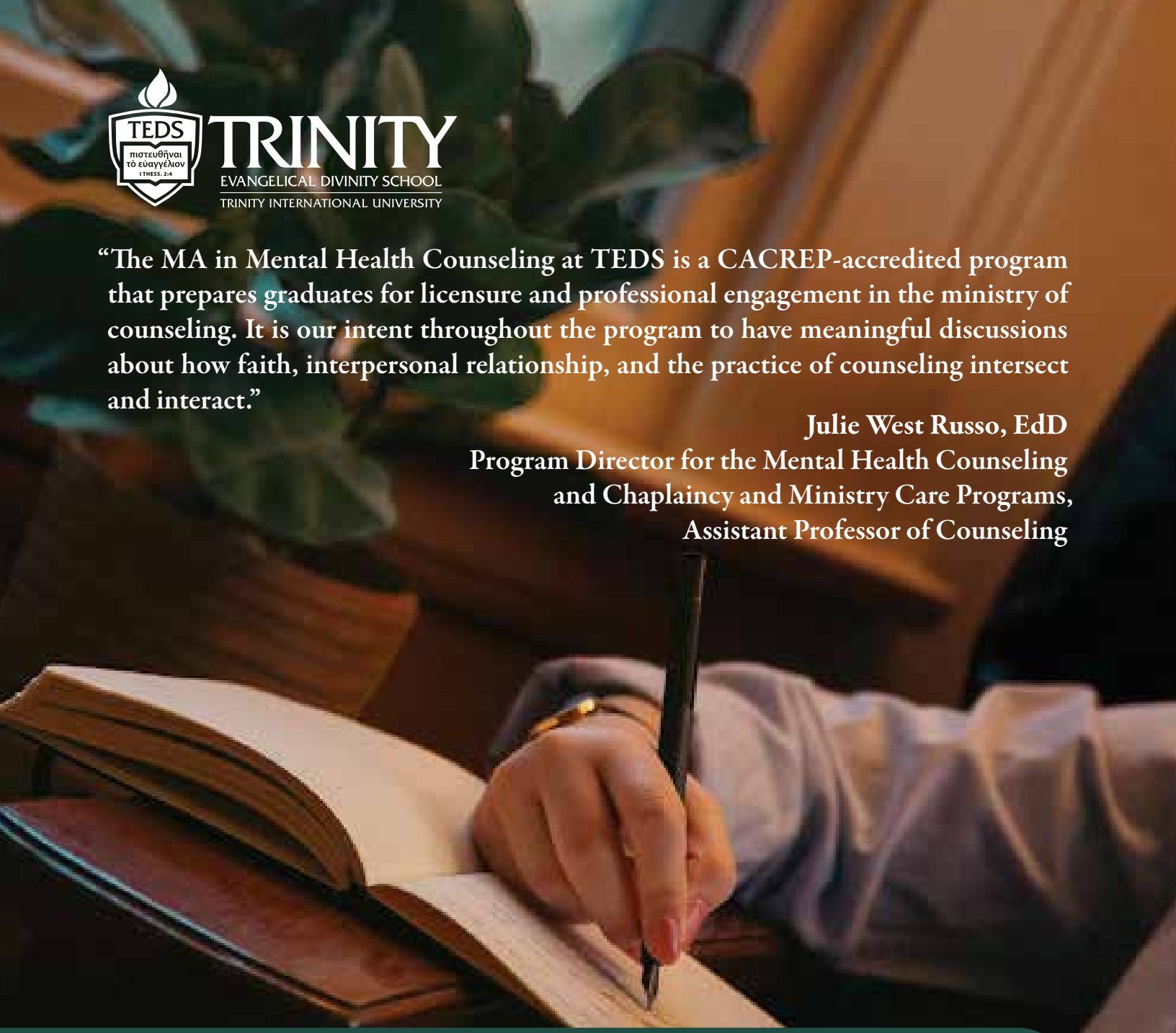

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Julie West Russo, EdD
Program Director for the Mental Health Counseling and Chaplaincy and Ministry Care Programs, Assistant Professor of Counseling

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