CLERGY LEADERSHIP & RESILIENCE

A CLERGY RESILIENCE PRACTICE

Healing from the Hurts of Ministry

Recognizing Woundedness and Finding the Care Healing Requires

LORNE BOSTWICK

Healing from the Hurts of Ministry

Recognizing Woundedness and Finding the Care Healing Requires

CLERGY LEADERSHIP AND RESILIENCE SERIES

Returning reader? Skip the Series Introduction and go directly to Beginning Here.

About the Clergy Resilience Series

Ministry can be deeply life-giving. It can also wear you down.

The work asks us to enter people's grief, conflict, fear, hope, illness, joy, disappointment, and change. We preach and teach, lead organizations, respond to crises, manage conflict, accompany people through suffering, celebrate with them, make decisions, and carry responsibilities few people in our congregations ever fully see.

Sometimes we do all of that while trying to make sense of what is happening in our own lives.

Over time, ministry leaves its mark.

You may notice that you are more tired than you used to be. Criticism stays with you longer. You carry other people's problems home. Saying no produces guilt. Conflict occupies your mind long after the meeting ends. Prayer has become something you do professionally rather than something that nourishes you. Perhaps you feel lonely, spiritually dry, cynical, constantly hurried, or simply beaten up.

These experiences do not necessarily mean you are failing at ministry.

They may mean that something deserves your attention.

Resilience Is More Than Endurance

Clergy resilience is sometimes understood as the ability to withstand the pressures of ministry—to become tougher, develop thicker skin, recover more quickly, and keep going.

But resilience is not simply endurance.

Nor is it another name for self-care.

Resilience is the developing capacity to remain personally healthy, relationally connected, spiritually grounded, and vocationally faithful through the ordinary and extraordinary stresses of ministry.

That capacity develops over time.

Emotional awareness helps us recognize what is happening within us. Differentiation helps us distinguish what belongs to us from what belongs to someone else. Boundaries protect what matters. Relationships keep us from practicing ministry alone. Prayer reconnects us with the source of our vocation. Rest and recreation restore capacities that ministry consumes. Attention to sleep, nutrition, movement, and physical health reminds us that our bodies are not separate from our spiritual and emotional lives. Systems awareness helps us remain grounded when congregations become anxious. Reflection and discernment help us recognize when something needs to change.

These are not techniques for making us invulnerable.

They are practices that help us remain available to God, to others, and to ourselves.

Self-Giving, Not Self-Erasure

Christian ministry involves sacrifice.

There will be nights when someone is dying and sleep will have to wait. There will be seasons when the needs of a congregation require more from us than usual. Love costs something. Vocation costs something. Following Christ has never promised a life protected from sacrifice.

The question is not whether ministry will ask something of us.

It will.

The more important question is what kind of sacrifice faithfulness requires.

Jesus' life was profoundly self-giving, but it was not indiscriminately available. He withdrew to pray. He rested. He received food and hospitality. He lived in relationship with companions. He left places where people were still looking for him. He sometimes moved toward one need while passing by another. The existence of a genuine need did not, by itself, determine what he was called to do.

That matters for pastors.

People may genuinely need us and yet their need may not always be ours to meet. Someone may be disappointed by a boundary we establish without that boundary being unfaithful. Rest may sometimes be more faithful than another meeting. Prayer may take us away from people who want our attention precisely because we need to remember whose ministry this is.

Christian ministry calls us to self-giving, not self-erasure.

Resilience helps us give ourselves faithfully without losing the self God has given us to offer.

The distinction matters because suffering itself is not evidence of faithfulness. Exhaustion is not proof of devotion. Being indispensable is not the same as being called. Allowing ourselves to be consumed by every legitimate need around us does not necessarily make us more Christlike.

Faithful sacrifice is ordered toward life.

Sometimes it asks a great deal of us. Sometimes it stretches capacities we did not know we possessed. But resilience helps us recover, learn, mature, and return. It preserves and develops our capacity to love, serve, discern, and give again.

So one question runs quietly beneath every resource in this series:

> **Is this helping me become more capable of faithful self-giving, or am I simply being consumed?**

Start Where You Are

This series is not a training program to complete.

There is no prescribed sequence. There is no expectation that you work through every resource. You may never need some of them.

Begin instead with what is wearing on you now.

Perhaps you need stronger boundaries. Perhaps you need to understand why a particular situation makes you so angry. Maybe you need relationships in which no one needs you to be their pastor. Perhaps you need a way to recover after demanding weeks, or help sorting out what belongs to you and what you have been carrying for someone else.

Perhaps ministry has hurt you and you need to tend the wound.

Perhaps you have stopped doing things that give you joy.

Perhaps your body is telling you something you have been too busy to hear.

Perhaps you are beginning to wonder whether something about your vocation needs to change.

Start there.

Each resource in this series focuses on one dimension of clergy resilience. It is designed to be read in about an hour and practiced for approximately a month.

The reading introduces the practice.

The month is where the learning happens.

You will be invited to notice what happens in ordinary ministry, experiment with a few practices, reflect on what you discover, and gradually decide what is useful enough to carry forward.

There is nothing to complete here.

You are practicing, not performing.

If you miss several days, begin again. If a practice doesn't fit, adapt it. If you discover that the issue you started with isn't really the issue, follow what you are learning.

The purpose is not to become proficient at another program. It is to become more attentive to yourself, your relationships, your vocation, and the presence of God within all of them.

You Were Never Meant to Do This Alone

Personal practices matter, but clergy resilience is not solely an individual responsibility.

Sometimes pastors become depleted because we have developed unhealthy patterns. Sometimes we are depleted because we are serving within unhealthy systems. Often both are true.

No amount of emotional intelligence can make an abusive situation healthy. Better boundaries cannot eliminate every unreasonable expectation. Prayer cannot substitute for sleep. A vacation cannot repair chronic organizational dysfunction. And resilience should never become an excuse for asking clergy to endure circumstances that need to change.

Healthy resilience includes knowing when we need someone else.

A trusted colleague, friend, clergy cohort, coach, spiritual director, therapist, physician, mentor, or denominational leader may sometimes be part of what faithful resilience requires.

Seeking support is not evidence that resilience has failed.

Relationship is one of the ways resilience develops.

One Practice at a Time

You do not need to become perfectly resilient before you can practice healthy ministry.

Resilience develops as we live.

Notice one thing.

Practice one thing.

Pay attention to what changes.

At the end of the month, you may decide to continue the practice. You may choose another resource because something else now needs attention. Or you may simply return to your life and ministry carrying one new capacity with you.

> **That is enough.**

Read for an hour. Practice for a month. Then ask what you need next.

Beginning Here

Ministry leaves marks.

Some are signs of love given and received: names remembered in prayer, stories entrusted to you, communities that changed you, lives in which you were permitted to share. Other marks come from criticism, betrayal, conflict, rejection, public accusation, institutional abandonment, congregational division, or the slow erosion of trust.

Pastors are often expected to absorb these injuries and continue. The sermon still must be preached. The hospital call must be answered. The meeting cannot always be postponed. People who had no part in the injury still deserve care. Competence can conceal pain for a long time.

But continuing to function is not the same as healing.

A wound may remain long after the crisis has ended. It can live in thoughts that circle without resolution, a body braced for danger, an emotion that arrives with unexpected force, a prayer that no longer comes, a relationship that cannot be trusted, or a leadership decision still governed by what happened years ago.

This booklet will not heal a ministry wound in four weeks.

It is not trauma treatment, psychotherapy, spiritual direction, medical care, or a substitute for professional assessment. It does not ask you to forgive on schedule, recover quickly, prove your resilience, or return to usefulness before you are ready.

It offers something more modest and more honest: a month of practice in recognizing woundedness, searching for appropriate care, entering a healing relationship, and beginning a care plan.

The central question is:

> **What kind of wound am I carrying, what kind of care does it require, and how can I become an active participant in healing for as long as healing takes?**

Pain, Woundedness, and Healing

Not every painful experience becomes an enduring wound.

Ministry includes disappointment, disagreement, loss, criticism, failure, and change. Some pain moves through us with rest, prayer, honest conversation, repair, wise companionship, and time. We remember what happened, but the memory no longer organizes the present.

A wound persists differently. It alters the way we experience ourselves, other people, God, ministry, or the world. It may remain quiet until something touches it. Then the past rushes into the present with surprising force.

A routine question sounds like an accusation. A delayed email feels like abandonment. A disagreement in a new congregation awakens the fear created by an old conflict. The body tightens before the mind knows why. The pastor withdraws, overexplains, appeases, controls, attacks, or prepares to leave.

These responses are not evidence of weakness. Many began as ways to survive, protect what mattered, or remain functional. Yet a protection that once helped may later narrow life and leadership.

Healing is not forgetting what happened. It does not require restoring trust where trustworthiness has not been demonstrated. It does not erase accountability, excuse misconduct, or make reconciliation safe in every circumstance.

Healing is the gradual work by which the wound becomes part of your story without remaining the hidden author of your life.

Ministry Wounds Do Not All Take the Same Form

Some wounds gather around a single event: a public accusation, a threatening encounter, a forced departure, or betrayal by someone trusted. Others accumulate through years of criticism, chronic conflict, isolation, exposure to suffering, impossible expectations, or responsibility carried too long without adequate support.

Some are wounds of loss: a congregation loved, a community left, a future that will not unfold, or a call that ended without blessing. Some are wounds of betrayal, deepened because the people or institutions that caused harm claimed spiritual authority or a duty of care. Some are moral and spiritual wounds, arising when the pastor participated in, witnessed, could not prevent, or had to survive actions that violated deeply held convictions.

These experiences can overlap with grief, burnout, depression, anxiety, traumatic stress, moral injury, spiritual abuse, or physical illness, but the words are not interchangeable. A booklet cannot determine which description fits. Careful assessment matters because the name given to suffering shapes the care that follows.

The question, then, is not only, "Where do I carry this?" It is also, "What kind of injury may have occurred, what remains active, and who is qualified to help me understand it?"

We Carry Wounds in More Than One Place

Human beings do not divide neatly into mind, body, emotion, spirit, relationship, and vocation. An injury in one dimension can reverberate through all the others. Noticing these dimensions is not an exercise in self-diagnosis. It is a way to describe your experience clearly enough to seek fitting care.

Where a wound is felt most strongly offers a clue, not a prescription. Bodily symptoms do not automatically require one particular body-based method. Spiritual pain does not mean spiritual direction is sufficient. A competent assessment may reveal that several forms of care should work together or proceed in a particular order.

In the Psyche

A wound may be carried in recurring thoughts, meanings, memories, and expectations:

- "No congregation can be trusted."
- "If anyone is unhappy, my ministry is in danger."
- "I must anticipate every criticism before it is spoken."
- "If I make another mistake, I will be rejected."
- "Institutions always protect themselves."
- "What happened proves that I was never called."

The pastor may replay conversations, imagine different endings, struggle to concentrate, avoid reminders, or interpret every new relationship through an old injury. The mind returns again and again to what it cannot yet integrate.

In the Body and Nervous System

The mind may know that a conflict is over while the body remains prepared for danger.

- The heart races before a session or board meeting.
- The stomach tightens when a particular name appears on the phone.
- The jaw and shoulders remain tense.
- Sleep becomes shallow or fragmented.
- The pastor freezes when publicly challenged.
- The voice disappears in conflict.
- Exhaustion follows ordinary interpersonal strain.
- A room, tone of voice, or facial expression triggers alarm.
- The pastor feels numb, detached, or unable to inhabit the body fully.

These responses deserve attention. Physical symptoms also deserve medical evaluation; not every bodily experience should be attributed to stress or trauma.

In the Emotions

The wound may appear as anger, grief, fear, shame, irritability, dread, or emotional flatness.

A pastor may remain composed at church and erupt at home. Grief may break through without warning. Shame may make visibility unbearable. Anger may become the only emotion that still feels safe. Numbness may be mistaken for forgiveness. Even joy may produce guilt while the injury remains unresolved.

Emotions are not verdicts. They are forms of information. They may tell us that something mattered, something was violated, something remains unsafe, or something still waits to be mourned.

In the Spirit

Ministry wounds can injure the pastor's relationship with God, Scripture, prayer, worship, calling, and the church.

- Prayer feels empty or professionally contaminated.
- Biblical language used during conflict now provokes resistance.
- Forgiveness sounds like a demand to silence accountability.
- The pastor feels abandoned by God.
- The call to ministry feels like a divine betrayal.
- God becomes confused with the congregation or denominational authority.
- Leaving an unhealthy setting feels like abandoning God.
- The pastor can preach grace but cannot receive it.

Spiritual injury is not necessarily a failure of faith. Lament, protest, silence, and bewilderment also belong within a life of faith.

In Relationships

A wound received in relationship often travels into the relationships that follow.

The pastor may stop delegating, expect betrayal, withhold vulnerability, appease powerful people, or test others without telling them they are being tested. The family may become the only trusted social world. Colleagues

may be treated as competitors or potential informants. A new congregation may be asked, without knowing it, to prove that it is not the old one.

In Vocation and Leadership

The wound may shape both how the pastor leads and what future the pastor can imagine.

Every disagreement can feel like the beginning of another campaign. The pastor may become controlling, hesitant, compulsively available, emotionally absent, or unable to make decisions. The pastor may remain in a damaging call because departure feels like defeat—or leave whenever ordinary conflict appears.

Healing may include recovering the call, changing the conditions under which it is lived, or recognizing that faithfulness now requires departure.

Different Wounds May Require Different Care

"Find a therapist" can be wise advice, but it is not yet a care plan.

Psychotherapists differ in training, licensure, treatment methods, experience, and scope. Spiritual directors, coaches, physicians, psychiatrists, art therapists, movement practitioners, mediators, and denominational leaders also offer different forms of help. No single practitioner should be presumed competent to treat every expression of woundedness.

A general psychotherapist may be an excellent starting point for assessment and referral. Some concerns, however, require specialized expertise.

The reader should not have to become a treatment expert before asking for help. The first wise step may be finding a well-qualified clinician, physician, or other professional who can assess broadly, explain options, and refer responsibly. Choosing appropriate care is a shared discernment, not one more burden the wounded pastor must carry alone.

Psychotherapy and Trauma-Focused Care

Psychotherapy can help with emotional processing, patterns of thought and behavior, relational difficulties, grief, depression, anxiety, and many other concerns. When symptoms include intrusive memories, persistent avoidance, hyperarousal, dissociation, or possible posttraumatic stress, ask specifically about trauma assessment and treatment.

"Trauma-informed" does not necessarily mean trained to provide trauma-focused therapy. Evidence-based treatments for PTSD include specialized approaches such as cognitive processing therapy, prolonged exposure, trauma-focused cognitive behavioral therapy, and, in some circumstances, EMDR or other structured treatments. A qualified clinician should help determine what fits the person, their symptoms, history, preferences, and risks.

Art Therapy

Some experiences resist ordinary speech. They may be carried as images, fragments, sensations, metaphors, or memories that seem flattened by explanation.

Art therapy uses active art-making, creative process, psychological theory, and a psychotherapeutic relationship. It can offer forms of expression beyond words and engage sensory, symbolic, and kinesthetic experience. It is a mental health profession practiced by appropriately trained and credentialed art therapists. Recreational art can be restorative, but it is not the same as art therapy.

Somatic and Movement-Based Care

When woundedness is carried strongly through bodily alarm, freezing, tension, disconnection, or restricted movement, care that attends explicitly to the body may be helpful. This might include a psychotherapist trained in body-oriented methods, dance/movement therapy, trauma-sensitive movement, or another appropriately credentialed practitioner.

The terms in this field are not interchangeable, and evidence varies among methods. Body-oriented practices may complement trauma-focused psychotherapy; they should not automatically replace clinical treatment. Pain, sleep disturbance, dizziness, heart symptoms, or other physical changes may also require a physician, physical therapist, or another medical specialist.

Spiritual Direction and Pastoral Care

Spiritual direction may be especially helpful when the wound affects prayer, calling, theological meaning, spiritual practice, or the pastor's relationship with God. A skilled director can accompany lament, silence, anger, discernment, and the slow recovery of spiritual receptivity.

Spiritual direction is not a substitute for clinical treatment of PTSD, major depression, suicidality, dissociation, or other mental health conditions unless the director is also appropriately licensed and is working within that professional role. Conversely, not every psychotherapist understands ministry, ecclesial systems, spiritual abuse, or the difference between a crisis of faith and a symptom.

Other Members of a Care Constellation

Healing may require a constellation of relationships:

- A grief specialist when loss is central
- A couples or family therapist when the wound has entered the household
- A physician or psychiatrist when sleep, pain, panic, depression, medication, or physical symptoms require evaluation
- A peer group when isolation and shame sustain the wound
- A coach or pastoral consultant when healing must be translated into leadership practices
- A mediator or systems consultant when relationships or organizational patterns need attention
- Denominational, safeguarding, legal, or misconduct processes when protection, correction, or accountability is required

Personal healing cannot substitute for institutional justice. Nor can an institutional process provide all the care an injured person may need.

A Month for Beginning, Not Finishing

The next four weeks cultivate four cumulative skills:

> **Recognize Woundedness → Search for Appropriate Care → Enter a Healing Relationship → Begin and Work a Care Plan**

During Week One, you will notice and describe the ways a wound may be living in you.

During Week Two, you will identify the expertise you need and begin searching for appropriate care.

During Week Three, you will prepare to enter a healing relationship as an active participant.

During Week Four, you will begin shaping a care plan and a way to review it over time.

The month does not promise a diagnosis, a perfect provider, instant trust, rapid relief, or completed healing. It offers skills for beginning care and remaining engaged with it.

Each movement remains in use as the next is added. Week Two carries forward the wound map from Week One. Week Three uses the questions and criteria developed during the search for care. Week Four turns the emerging healing relationship into a plan that can be sustained, reviewed, and revised.

These movements may not fit neatly into four calendar weeks. Waiting lists, finances, location, readiness, and provider availability may slow the process. Continue practicing the movement you are in while taking the next available step. The calendar offers structure, not a deadline.

Week One — Recognize Woundedness

Notice What Has Changed

Choose one ministry experience that still carries unusual force. Do not begin with the most overwhelming event if approaching it alone feels unsafe. You might begin with a recent moment when an older hurt seemed to enter the room.

Complete these sentences:

- Before this happened, I was more able to…
- Since it happened, I have found myself…
- The situations I now avoid are…
- The situations I try to control are…
- The people closest to me have noticed…
- The part of ministry that changed most is…

Build a Wound Map

For several days, notice without forcing an explanation.

Psyche

What thoughts, beliefs, memories, or predictions recur? What story does the wound tell about you, other people, God, or the future?

Body

Where do you notice tension, activation, fatigue, numbness, pain, or disrupted sleep? What happens before meetings, emails, conflict, or public leadership?

Emotions

What emotions arrive? Which emotions are difficult to feel? Which seem to cover something more vulnerable?

Spirit

What has changed in prayer, worship, Scripture, calling, hope, or your sense of God's presence?

Relationships

Where have trust, openness, delegation, conflict, or intimacy changed? Who is living under the shadow of what someone else did?

Vocation

How has the experience affected leadership, decision-making, risk, boundaries, or your imagination of the future?

Notice Activation

An activated response is not necessarily irrational. Something in the present may genuinely deserve concern. The question is whether this moment is carrying the full weight of the past.

When you notice a strong response, write briefly:

- What happened just now?
- What did I feel in my body?
- What meaning did my mind give it?
- What did I want to do?
- What older experience did it resemble?
- What would help me assess the present more clearly?

Know When Not to Practice Alone

Stop and seek immediate professional or emergency help if you are in danger, unable to function safely, considering harming yourself or someone else, experiencing severe dissociation or loss of contact with reality, or facing abuse, threats, stalking, or ongoing misconduct.

This booklet cannot assess risk. Use local emergency services or crisis resources appropriate to your location, and involve qualified professional care.

At the End of Week One

Write a one-page description beginning:

> **I am concerned that I may be carrying a wound because…**

Include what happened, what changed, where the wound appears, what activates it, and how it affects daily life and ministry.

Week One has done its work when you can describe what needs attention without demanding that you diagnose it.

Week Two — Search for Appropriate Care

Begin with the Need, Not a Provider's Title

Review your wound map. Which expression causes the greatest disruption? Which feels least understood? What kind of assessment might clarify what is happening?

You may need a starting practitioner who can assess broadly and refer wisely. You may already know that specialized trauma, grief, art, movement, couples, medical, psychiatric, spiritual, or organizational care deserves consideration.

Do not assume that the place where you feel the wound most strongly identifies the treatment by itself. Bring the whole map. A clinician may need to consider sleep, medical conditions, medication, trauma history, current danger, relationships, substance use, spiritual injury, and daily functioning before recommending care.

Search for Relevant Expertise

As you review directories, referrals, and provider profiles, look beyond reassuring language.

Ask:

- What credentials and licensure govern this person's work?
- What training do they have in the symptoms or wounds I am experiencing?
- Have they worked with clergy, religious systems, spiritual abuse, or vocational injury?
- What treatment approaches do they use, and for what concerns?
- How do they assess whether a referral or additional specialist is needed?
- How do they understand the place of faith in care?
- How will we know whether the care is helping?

A provider need not share all your beliefs. But a provider should be able to treat faith neither as pathology nor as an answer that makes assessment unnecessary.

Also ask whether the provider's claimed expertise is supported by relevant education, supervised training, licensure or credentialing, and current competence. Warmth matters. So do scope and skill.

Consider Practical Access

Appropriate care must also be possible to reach and sustain.

Consider cost, insurance, travel, telehealth, schedule, accessibility, cultural understanding, confidentiality, and denominational implications. Ask whether your congregation, presbytery, diocese, synod, judicatory, employer, or professional association provides confidential assistance.

If the institution contributed to the wound, institutional funding should not automatically give the institution access to the content of care. Clarify confidentiality before accepting assistance.

Make More Than One Contact

The first call may lead to a waiting list, a referral, or a poor fit. None of these is rejection or failure.

Identify several possible starting points. Ask a trusted physician, therapist, spiritual director, colleague, or denominational care professional for specific referrals. “Who is trained to work with this?” is often more useful than “Do you know a good counselor?”

Practice Scenario

A pastor has recurring nightmares, becomes physically alarmed before congregational meetings, and cannot pray without remembering language used to justify harmful treatment. A colleague recommends a beloved spiritual director.

The director may become part of the care constellation. But what additional assessment is indicated? What questions would help determine whether trauma-focused clinical care is needed? How might spiritual direction and psychotherapy serve different parts of the wound?

At the End of Week Two

Complete:

- The most disruptive expression of the wound is…
- The kind of assessment or expertise I am seeking is…
- The qualifications that matter are…
- The first three contacts I can make are…
- The practical obstacle I need help addressing is…
- The person or body that may help remove that obstacle is…

Week Two has done its work when you know what kind of care you are seeking and have made at least one concrete contact.

If a provider is not yet available, preserve the search plan and identify safe interim support. Interim support is not a substitute for needed treatment, but it can reduce isolation and help you continue the search.

Week Three — Enter a Healing Relationship

Let Yourself Receive Care

Pastors are practiced at becoming the caregiver in the room. Receiving care can awaken shame, self-consciousness, intellectualization, excessive agreement, or the urge to reassure the practitioner that you are doing well.

You do not need to perform insight, faith, composure, or recovery for the person caring for you.

You may arrive uncertain. You may need an explanation. You may tell the story slowly. You may ask whether the proposed care fits.

Prepare for a First Conversation

Bring your Week One description if it helps. You do not need to disclose every detail immediately. A useful beginning includes:

- What happened, in broad outline
- What you are experiencing now
- How daily life, relationships, faith, and ministry are affected
- What makes the concern better or worse
- Previous care and what was or was not helpful
- Medications, medical issues, substance use, or safety concerns relevant to assessment
- What you hope may become possible

Ask About the Work

You may ask:

- How do you understand what I have described?
- Is further assessment needed?
- What approach would you recommend, and why?
- What are the goals, risks, benefits, and alternatives?
- What should I expect between sessions?
- How will we monitor progress?
- What would lead you to recommend another specialist?
- How do you handle spiritual concerns?
- What are the limits of confidentiality?

A responsible provider will not be threatened by reasonable questions.

Discern Fit Without Demanding Immediate Comfort

Healing relationships can be uncomfortable. Telling the truth, encountering grief, or changing protective patterns may not feel easy. Discomfort alone does not mean the care is wrong.

But feeling chronically dismissed, coerced, shamed, spiritually manipulated, culturally unseen, or unsafe should not simply be endured. Notice whether the provider listens, explains, respects limits, receives questions, and remains within professional competence.

Trust may grow slowly. You retain the right to seek consultation, request a referral, or choose another provider.

Whenever possible, agree on an initial period after which you and the provider will review fit, understanding, goals, and early response. This makes discernment part of the relationship rather than a private verdict the pastor must reach alone.

Practice Scenario

A pastor meets with a psychotherapist who seems warm and capable but repeatedly interprets prayer as avoidance and treats vocation primarily as an unhealthy attachment to work. The therapist has little experience with clergy or religious life.

What questions might clarify whether the therapist can become more curious? When might another clinician be a better fit? Could a spiritual director complement the work, or is the clinical relationship itself failing to respect an essential part of the pastor's life?

At the End of Week Three

Reflect:

- What did I feel before, during, and after the conversation?
- What seemed understood?
- What needs further explanation?
- What approach was proposed?
- What questions remain?
- Did the provider recognize the limits of their competence?
- What is my next step with this person or another provider?

Week Three has done its work when you can enter care as an active participant—honest about what you need, curious about the process, and free to assess the relationship.

Week Four — Begin and Work a Care Plan

Make the Plan Larger Than Appointments

A care plan is more than a calendar of sessions. It names what is being addressed, who is helping, how the parts relate, what support is needed, and how progress will be reviewed.

It may contain more than one track. Treatment can address symptoms and functioning. Spiritual care can accompany questions of God and vocation. Organizational action can address unsafe conditions. A misconduct, legal, or accountability process can pursue protection and justice. These tracks may affect one another, but none should be asked to do the work of all the others.

With appropriate providers, identify:

- The concerns being assessed or treated
- The goals of care
- The treatment or healing approaches being used
- The role of each practitioner
- The expected frequency of appointments
- Practices to use between appointments
- Signs of progress or increasing difficulty
- Symptoms or risks requiring additional care
- Workload, boundary, leave, or safety changes that may be necessary
- A date for reviewing the plan
- The distinct steps needed for safety, accountability, or institutional repair

Coordinate Without Losing Confidentiality

You may want a therapist, physician, spiritual director, or other practitioner to coordinate particular aspects of care. Such communication should occur only with your informed permission and within appropriate professional boundaries.

Congregational or denominational leaders may need to support leave, workload changes, finances, or safety. They do not thereby acquire a right to the private content of treatment.

Expect Uneven Progress

The different dimensions of a wound may heal at different rates.

The story may become clearer before the body feels safe. Sleep may improve before trust returns. Anger may intensify when numbness begins to lift. Prayer may remain difficult after clinical symptoms ease. A pastor may regain professional competence while still grieving the congregation that was lost.

Uneven progress is not necessarily failure. Neither is a referral, a revised diagnosis, a change in method, or the decision to seek another provider.

Review Whether Care Is Helping

At an agreed interval, ask:

- Are the goals still the right goals?

- What has changed in daily functioning?
- What symptoms have improved, persisted, or worsened?
- Do I understand the treatment and my part in it?
- Is the pace tolerable and purposeful?
- Is another specialty or form of support needed?
- Are the demands of ministry undermining care?
- Does the plan need to change?

Practice Scenario

A pastor begins trauma therapy and spiritual direction while continuing a ministry schedule filled with evening meetings, crisis coverage, and public conflict. The pastor attends every appointment but remains exhausted and repeatedly activated.

Is the problem insufficient commitment to treatment—or a care plan that has not addressed the conditions surrounding the wound? Who has responsibility for workload, coverage, safety, and leave? What must change for care to have room to work?

At the End of Week Four

Write your present care plan:

- What I am addressing…
- Who is helping and in what role…
- What I am practicing between appointments…
- What support or accommodation I need…
- What remains urgent or uncertain…
- How I will recognize progress…
- When and with whom I will review the plan…
- The next step I will take…

Week Four has done its work when you have begun a care plan, know the next steps, and have a way to review and revise the plan over time.

When the Church Must Participate in Care

Healing is personal, but ministry wounds are not always private matters.

When a congregation, governing body, staff system, or denominational process contributed to harm, it may have responsibilities beyond encouraging the pastor to seek counseling. These can include stopping ongoing behavior, correcting false information, enforcing policy, providing financial assistance, arranging coverage or leave, addressing unsafe systems, and making honest institutional repair.

Therapy must never become the means by which an institution relocates its responsibility into the injured person. Paying for care can be part of institutional responsibility, but it is not the same as stopping harm, correcting a record, enforcing policy, or making repair.

At the same time, a pastor's healing cannot always wait for the institution to become accountable. Appropriate care may help the pastor recover agency, make decisions, establish boundaries, and pursue justice without making institutional recognition the condition of every next step.

A Coach's Reflection

Healing Is Not Another Clergy Performance

Pastors know how to turn almost anything into an assignment.

They can perform insight for the therapist, faith for the spiritual director, stability for the congregation, and progress for the family. They can turn the care plan into one more standard they are failing to meet.

But healing is not a demonstration of vocational fitness.

You are not required to produce a redemptive meaning for what happened. You do not have to call the wound a gift. You do not have to reconcile where reconciliation is unsafe. You do not have to become the person you were before.

The wounds of the risen Christ were not erased. Neither did they have the final word.

Christian hope does not deny injury. It trusts that injury need not become identity, destiny, or the limit of future life. Resurrection does not demand that we call the wound good. It is God's refusal to let the wound possess the whole future.

Carry This With You

Recognize Woundedness

What has changed, where am I carrying it, and how is the past entering the present?

Search for Appropriate Care

What expertise fits the way this wound is living in me?

Enter a Healing Relationship

What must a practitioner understand, and what do I need to ask in order to participate wisely?

Begin and Work a Care Plan

Who is helping, what are we doing, what support is required, and when will we review the plan?

And remember:

> **The month has done its work not when the wound is healed, but when you are better able to recognize what needs care, seek help suited to the wound, enter care as an active participant, and continue a plan for as long as healing requires.**

Closing Prayer

Wounded and risen Christ,

you do not ask us to deny what has happened or to hide the marks ministry has left upon us.

Meet us where memory circles, bodies brace, emotions overwhelm, prayer falters, trust narrows, and calling grows uncertain.

Give us courage to recognize what needs care, wisdom to seek those equipped to help, and freedom to receive care without shame.

Protect us from hurried forgiveness, spiritual bypassing, false reconciliation, and the demand to become useful before we have become well.

Guide therapists, physicians, spiritual directors, companions, families, congregations, and church leaders in the responsibilities that belong to them.

Where justice is required, strengthen us to seek it. Where boundaries are needed, help us keep them. Where grief must be carried, give us faithful company.

Let healing unfold at the pace of truth and grace.

May what wounded us become part of our story without becoming the author of our future.

Amen.

Notes on Care and Scope

This resource is educational and pastoral. It does not diagnose or treat any condition. Treatment decisions should be made with qualified professionals who can assess individual needs, risks, history, preferences, and context.

The descriptions of PTSD treatments and trauma care draw on current guidance from the American Psychological Association. The description of art therapy follows the American Art Therapy Association's definition of art therapy as a mental health profession practiced by trained clinicians. Evidence for body- and movement-oriented approaches varies; these may be useful as components of care or adjuncts to trauma-focused treatment.

In an emergency or when there is immediate risk of harm, contact local emergency services or an appropriate crisis service in your location.