Healthy Leaders: Multilevel Health Promotion Considerations for Diverse United Methodist Church Pastors

Sara LeGrand, PhD
Duke Global Health Institute, Duke University Center for Health Policy and Inequalities Research, Durham, NC

Rae Jean Proeschold-Bell, PhD
Duke Global Health Institute, Duke University Center for Health Policy and Inequalities Research, Durham, NC

John James
Duke University, Durham, NC

Amanda Wallace
Duke University, Durham, NC

Please direct comments to Sara LeGrand at sara.legrand@duke.edu

Abstract

Community psychologists often work with institutions and leaders, such as clergy, to bring about social change. Studies finding high rates of chronic disease among clergy have called for the design of clergy health interventions. However, among clergy there is substantial diversity. We conducted four focus groups with a cross-section of United Methodist clergy and one focus group each with female, local, young, and large-sized church pastors. We compared themes from the specific versus broader focus groups. Findings are as follows: female pastors felt guilty for taking personal time and experienced pressure to prove themselves; local pastors reported financial strain and utilized a variety of interpersonal relationships; young pastors indicated child-related stress but also greater interest in nutrition, exercise, and church-based health promotion; and large-sized church pastors expressed increased confidence in negotiating personal time and reported more sharing of pastoral duties. We organized themes by levels of the socioecological framework to guide intervention design.

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Introduction

Community psychologists should be interested in the health of clergy for four reasons. First, they are interested in how systems and the environment affect individuals, and clergy are embedded in congregation environments and denominational systems. Second, when change is desired, community psychologists have prioritized a number of strategies to promote it, including changing existing systems and policies (Moritsugu, Wong, & Grover- Duffy, 2009) and creating alternative settings (Cherniss, 2012). The religious institutions headed by clergy offer one example of a system that affects a large number of people. Third, community psychologists are interested in disparities, and clergy experience a health disparity in the form of higher rates of chronic disease than the general population (Proeschold-Bell & LeGrand, 2010). Finally, community psychologists sometimes seek to reach large numbers of people, and fostering the health of clergy may simultaneously serve to promote health among congregants within church settings.

Church settings and, more generally, faith settings, have a broad reach, with an estimated 55% of individuals in the United States attending worship events at least 1–2 times per month (Pew Forum on Religion & Public Life, 2008). It is unknown what role the ill health of clergy plays in the health of their congregants, but ecological frameworks posit links between organizations and individuals (Shinn, 1990), and studies have been able to demonstrate such links across time (McMahon, Keys, Berardi, & Crouch, 2011). In this article, we explore the interplay of the church setting, the clergy occupational role, and the systems that affect clergy, keeping in mind the goal of health promotion.

The Clergy Vocation

Clergy occupy a unique role in our society. Clergy are leaders for their congregations, and they often take on broader community leadership roles. A closer look at the work of clergy reveals that its essence is worship, preaching, teaching, and oversight of the congregation (Carroll, 2006). However, diverse and multiple tasks emanate from this work. The roles of clergy have been divided: professional (e.g., care giving, mentoring, and preaching); decisional (e.g., handling conflict and determining how to allocate resources); interpersonal (e.g., leading or acting as liaison); and informational (e.g., disseminating information; Kuhne & Donaldson, 1995). Such diverse roles position clergy to act as change agents both within and outside of their congregations, although that same diversity in roles can also lead to role strain and stress.

The United Methodist Church

Among the many Protestant Christian denominations in the United States, the United Methodist Church (UMC) has a long history. The origins of the UMC began in 1738 when John and Charles Wesley initiated efforts in England to renew the Church of England. As their success grew, they sent lay preachers to America, and many of their supporters immigrated to America, as well. In 1784, the movement became the Methodist Episcopal Church in America, which eventually merged with other denominations (the Evangelical Association and the Church of the United Brethren in Christ) to become the UMC in 1968 (The United Methodist Church, 2008). The

2012 Yearbook of American and Canadian Churches reported that the UMC, with 7.7 million members, is the second largest Protestant denomination in the United States, with only Southern Baptists having more members (Linder, 2012). In 2008, the UMC estimated that it had an additional 3.5 million members throughout the world, with an emphasis in Europe, Africa, and the Philippines (Tooley, November 2008).

While it is not possible to explicate fully the theology of the UMC here, one key aspect of its theology is a focus on the cooperation between people and God. UMC theology teaches that God intends reconciliation with all people through grace, but that human beings, because they have free will, may choose to respond or not. Those who respond positively constitute the church, whose mission, in UMC language is, "to make disciples of Jesus Christ for the transformation of the world," transformation meaning the elimination of poverty, war, injustice and other social ills, in accord with the teachings of Jesus (The United Methodist Church, 2008, p. 87.)

The structure of the UMC comprises organizational bodies based on geographical areas called Annual Conferences. For example, there are 63 Annual Conferences in the United States. These Annual Conferences are subdivided into districts, and churches reside within districts. Each Annual Conference is led by a bishop, and each district is led by a district superintendent. In terms of pastors, UMC pastors undergo substantial training. Most attend a 3-year seminary program resulting in a master's degree in divinity, followed by a probationary practice period that culminates in the status of elder. Alternatively, people may choose the local pastor route, in which they attend theological training in successive intervals across a 5-year period and are able to administer the sacraments only at the local church to which they are appointed. Bishops appoint both elders and local pastors to serve churches. The length of appointment may be short or long, but generally lasts 3 to 7 years. Pastors can serve one, two, three, or even four churches simultaneously.

Clergy Health

Until recently, little was known about the health of modern-day clergy. (In this article, we define health holistically as physical health, mental health, and spiritual well-being.) Regarding clergy health prior to 1950, a compilation of standardized disease rates among clergy in Europe and the United States from the 1600s to 1950 indicated longer longevity among clergy than their nonclergy counterparts (King & Bailar, 1969). However, a 2001 study of clergy from the Evangelical Lutheran Church in America found that 68% of survey participants were overweight or obese, in comparison to 61% of Americans (Halaas, 2002). Most recently, in a 2008 study of United Methodist clergy, Proeschold-Bell and LeGrand (2010) found that clergy had higher rates of obesity, diabetes, arthritis, high blood pressure, and asthma than nonclergy. Thus, at least some groups of clergy are experiencing obesity and chronic diseases at high rates.

In terms of mental health, clergy experience a number of stressors, such as frequent moves, financial strain, lack of social support, high time demands, and intrusions on family boundaries (Morris & Blanton, 1994). Lee and Iverson-Gilbert (2003) have conceptual- ized the antecedents of pastoral stress into four categories: personal criticism, boundary ambiguity, presumptive expectations, and family criticism. At their heart, these stressors are relational in

nature. As community psychologists, we are interested in both physical and mental health as important components of well-being.

Ecological Theories of Health

Community psychologists have long-recognized the role that environments play in human behavior. For example, community psychology has been heavily influenced by the work of Kurt Lewin (Lewin & Cartwright, 1951), who developed the study of environments on individuals (Ecological Psychology), and Urie Brofennbrenner (1979) who proposed three levels of environmental influence on the individual, namely, microsystems (interactions among family members and small groups), mesosystems (physical settings for school, work, and family life), and exosystems (large social systems such as politics and culture). This emphasis on the ecological perspective has been extended from the understanding of human behavior to intervention development; it is essential to understand the local context at multiple levels when creating interventions (Kelly, 2006; Trickett, 2009).

Multilevel, ecological models are therefore important to understanding clergy. To understand our data, we used the socioecological framework (McLeroy, Bibeau, Steckler, & Glanz, 1988), a theory of environmental levels of influence on health. The socioecological framework starts with the "intrapersonal" level of influence, defined as an individual's beliefs and attitudes. In prior research, intrapersonal conditions related to stress or health practices among clergy included work satisfaction, burnout, emotional exhaustion, self- assessment of success, and personal boundaries (Lee & Iverson-Gilbert, 2003; Meek et al., 2003; Morris & Blanton, 1994; Proeschold-Bell et al., 2011; Rowatt, 2001). The second level is interpersonal, namely, relationships with spouses, family, and close friends. Sup- port from families, satisfaction with family life, support from other pastors, and support from friends are related to clergy health (Meek et al., 2003; Morris & Blanton, 1994; Proeschold-Bell et al., 2011; Rowatt, 2001).

The third level is that of community. Congregations are an important community for clergy and have been recognized for their role in influencing clergy health. For example, the degree of criticism congregants exact on a pastor is often identified as an important predictor of clergy stress, satisfaction, and health (Lee & Iverson-Gilbert, 2003; Proeschold-Bell et al., 2011; Rowatt, 2001). Finally, the socioecological framework highlights the effects of institutional factors on health. For clergy, the institutional level may be represented by denominational practices, like the process of matching pastors to congregations. Thus, in our effort to understand clergy health, the levels of influence specific to clergy are helpful, as are factors that researchers have identified as relating to clergy health.

Individual Theory of Health

Although the socioecological framework directs us to attend to the multilayered systems in which clergy are embedded, it does not explain the behaviors of individuals. To better understand why clergy do and do not engage in health behaviors, we looked to the Integrated Behavioral Model, which combines a set of behavior change theories including the Theory of Reasoned Action and Planned Behavior, the Health Belief Model, and Social Cognitive Theory (Fishbein, 2009). The Integrated Behavioral Model postulates that before people behave in a

certain way, they must first intend to behave that way. Their intentions are influenced by their attitudes toward the behavior, the perceived norms regarding the behavior, and their perceived control or self-efficacy in regards to the behavior. In turn, their attitudes are influenced by their beliefs and expected outcomes of engaging in the behavior. Their perceived norms are influenced by what is said and done around them in terms of the behavior. Finally, their self-efficacy is influenced by their beliefs about how much power and control they have over the behavior. Ultimately, and of interest to community psychologists, is the fact that even if someone intends to enact a behavior, actual enactment of the behavior is influenced by environmental factors and individual abilities (Fishbein, 2009). We use the Integrated Behavioral Model to interpret several of the findings from this study and hypothesize challenges to be considered in designing health interventions for clergy.

Diversity Within Clergy

When we embarked on designing a health intervention for clergy, we began with focus groups to learn directly from clergy themselves about barriers to, and facilitators of, their health. During analysis of these data, we thought we heard different themes from four kinds of clergy: female pastors, large-sized church pastors, young pastors, and local pastors. Consistent with the concerns common of community psychologists (Moritsugu et al., 2009), we realized that these particular subgroups of clergy might offer insights related to clergy power structures. For example, young pastors may have less power than large-sized church pastors, who tend to be established in their clergy careers and have been appointed to coveted churches with higher salaries. Local pastors may have less power due to having less ministry education, as may female pastors due to gender biases still present among clergy and congregants (Frame & Shehan, 2005; Glover-Wetherington, 1996; Lehman, 2002).

We therefore held an additional focus group with clergy of each of these demographic groups to examine whether particular health-related experiences are more salient for them than for clergy in general. This article reports on differences in themes between focus groups with a cross-section of clergy and each demographically specific focus group. We believe that a more thorough understanding of the health-related experiences of different kinds of clergy and at each level of the socioecological framework will help inform the development of health interventions for clergy. Ultimately, holistic health promotion among clergy may serve to better their lives and those of their congregants and communities.

Methods

Data Collection

We conducted four initial pastor focus groups (N = 33) with heterogeneous samples of UMC pastors in North Carolina in January and February 2008. We recruited participants evenly from the two UMC conferences in the state, with attention to age, gender, race, and rurality. From the total sample, 63.6% of the participants were male and 36.4% female; 84.8% were aged 41–70 years; 36.4% were licensed local pastors and 51.5% were elders; 90.6% were White and 6.3% were African American. Clergy were identified using a published conference roster and were

invited to participate by phone or e-mail. The semi structured to unstructured focus group questions collected information about participants' conceptualization of health, barriers to and facilitators of health, and the perceived relationship between the congregation and the health of the pastor. Consistent with the grounded theory approach (Strauss & Corbin, 1998), we initiated data analysis during the data collection process. Based on initial analyses, we determined that specific groups of clergy may have different health-related experiences.

To investigate further these potential differences, we used theoretical sampling (Creswell, 1998) to recruit individuals who represented the demographic groups of interest. Four additional focus groups were held in May and June 2008. These groups comprised female clergy (n = 6), local pastors (n = 6), pastors younger than 35 years of age (n = 7), and clergy from large-sized churches (n = 7). We chose 35 years of age be- cause only 6% were aged 18–34 years. We defined large churches to be those of sufficient size to have more than one pastor on staff. The clergy who attended this focus group included some senior pastors and some associate pastors, representing churches ranging in size from 600 to 4,000 members. We allowed participants in these additional focus groups to possess characteristics of clergy in the other focus groups. For example, three young women participated in the young clergy focus group. We allowed for this overlap because to deny young women clergy the opportunity to describe the health-related experiences of young clergy would have resulted in a male-focused young clergy experience and ultimately would have systematically biased the sample of young clergy.

Focus groups were 60–90 minutes in length and were audiotaped and transcribed. Participants completed a demographic survey after the focus group. Lunch and travel reimbursements were offered as compensation. The study was approved by the Duke University Institutional Review Board.

Data Analysis

Regularities and patterns in the data were identified in an iterative process of data analysis by the four-person research team. Coding categories, which emerged from the data rather than from pre-existing hypotheses (Charmaz, 2001), were developed and transcripts were coded using Atlas.ti version 5.2 (Muhr & Friese, 2004). To promote confirmability, two members of the research team coded each transcript and reached consensus through discussion about any discrepancies (M. B. Miles & Huberman, 1994). We examined units of data from each code for integrated schema, known as pattern coding. To understand differences between subgroups of clergy, we compared the themes of the four general focus groups with the themes of each of the subgroups, and highlighted the differences. All research team members had to agree that a theme for the subgroup was different in order for us to include it in the results.

Guiding Principles

When compared with the overall sample, unique themes were detected in each of the four specialty focus groups. We categorized these themes into the socioecological framework levels of intrapersonal, interpersonal, congregational, and institutional conditions. The highlights of these findings are provided below and summarized in Table 1.

Female Clergy

Intrapersonal. Female clergy, who comprise 25% of UMC pastors in North Carolina, reported that gender expectations have a marked impact on their lives as pastors. Although many focus group participants reported a tendency to put everyone else's needs before their own, the female pastor focus group data suggested that this is often more pronounced among women because of the default role of women as the caretaker of the family and the congregation. According to one focus group participant:

> And you will get physically sick.... If you don't take your time and you don't rest your body, then you're going to experience stress. And I think, as women, one thing that sets us apart, too, is most of us have families.... So, that's hard because we are the nurturers for them as well as usually the nurturers in the church.

Table 1. Key Findings By Ecological Level and Clergy Type

	Female pastors	*Local pastors*	*Young pastors*	*Large-sized church pastors*
Intrapersonal	Less likely to protect personal time	Financial strain	Financial strain	More likely to protect personal time
	Prioritize needs of others; caregiver for both family and church			
Interpersonal	Fears of being judged by clergy peers	More support from clergy peers	Desire to have fun and spend time with peer pastors not talking about work	More support from clergy peers
	Fears that clergy peers will break confidentiality	More support from friends and family	Uncertain if they can trust / share with peer pastors	
Congregational	Congregants showing less respect for female clergy, resulting in pressure to win them over	Pressure from congregations for clergy and female spouses to be visible	Attuned to health issues among church members; Interest in church health programming	More skilled at coping with demands from the congregation
	Direct confrontation from congregants saying that women should not be pastors		Stress accompanying congregants' interest in the pastor's children or lack thereof	
Institutional	United Methodist Church institutional leaders listening to congregants' preferences for a male versus female pastor		Apprehension about sharing information with their supervisors for fear of career repercussions	Institutional-level ideas to prevent clergy burnout

Female pastors also noted difficulties setting boundaries to protect personal time. In discussions about time off and vacations, feelings of guilt were frequently expressed by female clergy:

> But I think we worry so much and we don't take that time. When that time comes, we're thinking, "What about this and what about that? I can't get away then." And like [she] said, we need to reaffirm each other in that as opposed to adding more guilt.

Interpersonal. Many clergy suggested that friendships with other clergy members are vital to their health and well-being because clergy peers share similar experiences that others may struggle to understand. However, the female focus group participants reported that female pastors may encounter challenges with these relationships because they want to prove themselves worthy of the pastorate. Female clergy may work diligently to maintain expected appearances, establish distance from feelings of vulnerability, and be reluctant to trust their peers—even female peers. One participant noted:

> I think we're concerned about being judged by another clergy person and our image changes to them. Or, if I reveal something that someone is going to think differently of me, if I'm honest about something.

Trust and confidentiality were concerns for female focus group participants. They perceived a lack of "safe places" to go among their clergy peers in the UMC conference to share emotional problems:

> I have seen [confidentiality] be broken within even covenant groups and things.... And I feel cut off many times. I feel lonely.... It would be nice to have somebody that you could have that kind of trust with and that kind of bond with, but I'm always worried about confidentiality.... And that's the spiritual and emotional health. You need to have that person.

Congregational. Other factors perceived to influence the health of female pastors were related to the relatively new ordination of women as UMC clergy, which began in 1956, and the lingering preference for a male pastor among some congregants. Compared with our other focus groups, participants in the female clergy focus group indicated that they feel increased pressure to work harder and perform better to prove themselves to congregants who would prefer a male pastor. In this case, congregational expectations around clergy gender influence the degree of internal pressure experienced by female pastors:

> I think we, because we're women, we try so hard because, with the ordination of women being as young as it is still.... Every [church] I've been I've heard the comment, "Well, we were hoping it was going to be a man" .... And I think you try and compensate, you overcompensate for that. Because you are female, you think, "I've got to work four times harder" .... And I think that puts a stress on us that's different from the men.

Institutional. Female participants perceived that some congregations openly resist accepting a woman as pastor. They expressed disappointment that the bishop or conference did not take a harder policy line in requiring that churches receive and affirm their duly appointed pastor regardless of gender:

> But why is that happening where [a church] can say... "we don't want a woman"? I've heard [the bishop] say you're going to be appointed regardless, but here again, who has got our back here?

Local Pastors

In the UMC, many congregations are led by licensed lay ministers, called "local pastors." Local pastors comprise 31% of UMC clergy appointed to congregations in North Carolina. Unlike elders in full connection, local pastors are not ordained and are usually not seminary trained. Although all UMC pastors serve in an itinerant polity and are appointed to their churches by the bishop, local pastors tend to itinerate less widely than elders and are more likely to be longtime residents of the communities where they minister. While elders are normally guaranteed a full-time appointment every year, local pastors receive no such assurances. Appointments of local pastors are made depending on the needs of the conference and are more likely to be part-time and at a lower salary.

Intrapersonal. Local pastors mentioned financial struggles and their relation to health more frequently than participants of the general focus groups. They expressed particular concern about their inability to afford health-promoting goods and services and voiced hopes that the conference might offer programs to subsidize health-related expenses:

> My wife and I are living on a shoestring budget. You have to realize, bad food is really cheap and good food like organic is really expensive, so maybe there could be some kind of offset for buying fresh produce.

> I know how much counseling costs. That would not be pretty on a clergy salary.

Interpersonal. Compared with the larger sample of participants, local pastors indicated a stronger reliance on interpersonal support from other clergy members and nonclergy friends and family. Examples of remarks made by local pastors about the need for support include:

> We have a covenant group and we can talk about our health issues and just like in Vegas, it stays there. I can call on them anytime . . . . There is an outlet. My husband and I asked about one when we moved there. If you don't have one, start one up.

> I also think that it's important to have peers outside who aren't clergy – friends and family who aren't clergy is helpful.

Congregational. Local pastors recognized strong congregational expectations around the visibility and constant availability of pastors and the wives of male clergy. The participants voiced concerns about the *resulting* impingements on free time, and thus the lack of time available for health practices and personal relationships:

> A lot of members just want to see you when they want to see you. Like in the church office. They might not need you but they want to see you.... "Where were you?"

> Christ got away to the mountain to pray. My wife and I get away and Friday night is our Sabbath–we gather with friends or alone.... It is a problem with the church because we are not visible enough. They actually wanted my wife to quit her job.

No specific *institutional*-level themes arose for local pastors.

Young Pastors

Intrapersonal. The focus group conducted with pastors younger than 35 years of age also revealed distinct experiences related to health. Young pastors identified financial limitations as a potential barrier to optimal health with more frequency than the overall sample. Newly ordained *pastors* typically have lower salaries than those who are older and have served longer, and age is correlated with length of time since ordination. As a result, health-related activities such as purchasing healthy foods and utilizing medical services may be a financial stretch for young pastors. For example, young focus group participants perceived difficulties in affording mental health care:

> Participant 1: Medical benefits for mental illness in the [UMC] conference are sorry. And when you're in a vocation that probably has that risk almost more than maybe any other vocation out there, really if you think about it, those should be, just numerically, those should be very good benefits. You shouldn't have to pay – I don't know, no telling what it is lately.

> Participant 2: Twenty or thirty [dollars]. It was more than that, I think. It was like 30 bucks. And if you are a pastor and you're a young pastor and your wife doesn't work, 30 bucks a week, that's huge.

Interpersonal. Young pastors discussed concerns about identifying peers whom they could rely on for *support* and trust with confidential health information. For example, one participant stated:

> I think some of the emotional health issues too... where do you go with that? Who do you trust that you can go to and talk about that and get some help with that? Because it's hard to know who to trust. You're not going to people in your church most of the time. You're not going to go to other pastors a lot of the time.... Who do you go to and what do you do with it? And I think that that's a big issue.

Although young pastors may have concerns about trusting others, there was general support for the role peers can play in enhancing clergy health. Some young pastors felt that official clergy *gatherings* were often dull or artificial. There was particular interest in gathering to have fun and "blow off some steam" instead of focusing on work-related development:

> At Annual Conference this year, we're actually going to attempt to do kind of the first young clergy gathering at Conference. And we're just, that's the thing, there's no agenda . . . I mean, we're getting together, we're eating and we're playing video games. Like, that's all that's on the agenda.

Congregational. Young pastors were also the most attuned to health issues, including the importance of a healthy diet and exercise. Several young pastors acknowledged the challenges associated with eating healthfully when foods offered at church functions are often unhealthy. One pastor described his strategy for coping with the church food culture:

> I don't eat at covered dishes anymore. If there is a meal at church, I come and I fellowship with everybody and then I go and eat either at home or eat something. And I think that's very unusual. And people say, "Aren't you going to eat? Aren't you going to eat?" And I'm like, "No. I'm good."

In addition to being more personally cognizant of health-related issues, young pastors were more likely to recognize health problems among congregants and the poor health norms that exist in the community. A conversation between two participants provides an example of the *attentiveness* of young clergy to congregant health challenges:

> Participant 1: People call it "the sugar," but it's diabetes. The sugar is diabetes and very few people realize that it's their diet that has brought on this diabetes. Most of the time it's not hereditary, it's just the diet of biscuits and gravy.
>
> Participant 2: And then you get, "I have sugar so I can only eat one donut." [laughter] No one in my congregation sticks to the diet that they're supposed to be on.

Unlike *other* clergy groups, young pastors discussed the unrealized potential of churches as a venue for health promotion efforts:

> But it seems like the local church would be the perfect venue to create programs for people to do with health. You know, as far as weight and exercise and that kind of stuff. It's tailor-made really in a lot of ways. There's no other organization in all of the United States that could facilitate that better than local church congregations, and we don't do anything.

Young *pastor* focus group participants reported that a congregational condition that may influence their health is related to having children. They indicated that congregants may pressure young clergy families to have children and may not respect the couple's privacy about the decision:

> And then back to the baby thing, too. Being a female minister, ever since we got married . . . "When are you having babies?" And everybody in the church, especially all the women, everybody in the church asks me that at least once a day. . . . They don't ask, "Do you want to have children?" It's just, "When are you having babies?

Institutional. One topic of interest for the young pastors group was an emerging conference program of mandatory peer-support groups among clergy. Several participants expressed their disdain for assigned peer groups, arguing that relationships among clergy should be allowed to unfold *naturally*.

> The conference is starting this mentoring peer accountability group thing which I think is good in theory, but I already have my peers. I already have a group that I'm accountable to and I don't want it mandated by my district superintendent.

Young pastors also expressed distrust in discussion about difficult and sensitive topics with their immediate supervisor, the district superintendent (DS). DSs evaluate pastors' performance and advise the bishop on future ministry assignments. The young clergy were keenly aware of the possibility that sensitive health information, particularly related to mental health challenges, shared with their DS may have a negative impact on future appointments:

> Oh, yes. If you're having an emotional issue, technically your district superintendent is your pastor but he's also your boss. And it's really hard to find a place where you can deal with some of your emotional issues and feel like it's being held in confidence. I have not personally experienced that, but I'm very guarded about what I tell my district superintendent because I know it's fair game at Cabinet meeting.

Large-Sized Church Pastors

Intrapersonal. Female, local, and young focus group participants often identified challenges to health resulting from stress or barriers to coping and positive health behaviors. However, large-sized church *pastors*, which comprise 24% of UMC clergy in North Carolina, provided examples of how they are able to reduce stress, enhance coping, or improve health practices:

> So, taking a spiritual retreat. Since the beginning of my ministry I've taken fifth Sundays off for a retreat, renewal, rest, rejuvenation. And that's been a great practice because then I know I have that time to focus on my spiritual life and carving it out for that and not thinking, "Oh, well, I'll get around to that. I don't know if I'll make it this year or next year."

Analysis of the focus group data also revealed that clergy of large churches were more knowledgeable about their options and rights regarding vacation time and were more empowered to *take* this time.

Interpersonal. Pastors of large churches more frequently expressed positive opinions about interpersonal relationships with their peers. Several participants credited a clergy group for their survival in the *ministry* during significant career hardships:

> You know, it's just a unique situation and I began feeling more and more and more isolated and, oh gosh, I think I'm going to cry. In a hard place. And there's nobody else that knows what we do than other clergy. So . . . I had worked with a lot of clergy through the years and finally, about two years ago I said to a group one time on the weekend, "I need you. Will you be there for me?" And they have been. And it's been salvation for me.

Congregational. Analysis revealed much less anxiety among large-sized church pastors about congregational-*level* conditions, and more good humor and acceptance of in- evitable minor stresses. These pastors discussed skills in pushing back against congregational demands and in knowing when their presence was vital and when it was not:

> And sometimes I think it's okay to put other stuff on the back burner if you've got a series of funerals. You've got a congregation with a lot of older people, you've got to put some of that programming back for a while until you can get to it. And just let the people know, "This is where I'm at. We'll get to it, or you can take it."

Institutional. An institutional factor that may allow some large-sized church clergy to protect personal time is the ability to share the workload with other staff members. As one pastor explained, "We have Fridays off, we rotate and all that kind of stuff."

Pastors *of* large churches had a number of specific ideas about how institutional structures could be changed to support clergy self-care throughout the conference:

> I wish we had–if a third party could work more closely with the incoming pastor. Or if maybe the pastor is already there, then the staff parish committee. What is the cycle? What is expected for study and for family leave? And advocate to work out a deal, to work out a process . . . . I think our system has some really good qualities, but when you have a diocese or a

> presbytery negotiating as a third party and setting that in place, I imagine that would help because it takes the emotion out of both sides.

This *pastor* draws on terms and examples (diocese and presbytery) from mainline denominations other than the UMC. This suggests that large-sized church clergy may have greater exposure to non-Methodist leadership structures and may be able to draw on a wider range of solutions, than the pastors of smaller UMC congregations.

Discussion

This study allowed for identification of intrapersonal, interpersonal, congregational, and institutional conditions that are perceived to influence the health of female pastors, local pastors, young pastors, and large-sized church pastors. Identification of these factors may support the design of clergy health interventions to meet the needs of subgroups of clergy, whose health, in turn, may ultimately benefit their congregants and communities. We organized the Results section into the ecological levels to facilitate intervention design.

In comparing our health-specific findings to general themes found by other re- searchers of female pastors, we determined that some prior research suggests that female clergy may receive more social support, including support from congregations, peers, and institutions, than male clergy (McDuff & Mueller, 1999). However, our findings were similar to those of Rowatt (2001) in which female clergy report loneliness resulting from a lack of close relationships. Because female clergy aim to prove their worthiness and competence to their church leaders, peers, and congregants, they do not want to display weaknesses and appear vulnerable. However, such protective measures may isolate them from sources of support, including other female pastors, which may otherwise help to alleviate stressors that are unique to their experience as females in a male-dominated profession. The Integrated Behavioral Model presented earlier places an emphasis on norms, in which perceived norms are established by the behaviors exhibited around them. Be- cause female clergy feel pressure to present themselves as capable and successful, they may collectively and unconsciously create a social norm in which female clergy do not admit their struggles. This may lead to social isolation and added pressure to focus on vocational success, to the detriment of personal health.

As in other studies (Rayburn, Richmond, & Rogers, 1986), participants in our female focus group reported that women felt a greater need to excel in the profession to overcome doubts about their competence as pastors by church leaders and congregations. In the current study, female clergy also spoke directly to how this need affects their health. This overcompensation among female clergy is likely to increase stress and diminish boundary setting. Related to the Integrated Behavioral Model, female pastors may experience less self-efficacy to engage in healthy behaviors, because they perceive less time available for self-care as they work extra hard to prove themselves.

The intrapersonal and interpersonal challenges faced by female clergy are largely the result of perceived or real concerns of congregations and church leaders about the competency of female pastors. Changes at the institutional level, such as explicit support of female clergy by UMC bishops and district superintendents to congregations, may facilitate changes in these views among congregants, which would ultimately help improve intrapersonal and interpersonal conditions for female pastors. Other researchers have discussed how bishops need to be advocates, and not just positive supporters, of women in the church assignment process (Glover-Wetherington, 1996).

Churches also have pastor-congregant structures in place. For example, in the UMC, each church has a Pastor-Parish Relations Committee (PPRC) that is responsible for letting pastors know what is on the minds of congregants and for feeding information from the pastor to the congregants. PPRCs could do a lot to support female pastors, including taking an explicitly supportive role of female pastors and encouraging female pastors to take vacation. Thus, the interplay between the UMC institution, the pastor, and the congregants is critical. While female pastors may fight to be noticed for their abilities as pastors, they may simultaneously be viewed by congregants as caregivers, which is a common role for women and which aligns with some elements of pastoral work. Congregants may unintentionally give stronger environmental cues to female pastors that they should put others first. Thus, even if female clergy intend to engage in health behaviors (per the Integrated Behavioral Model), that intent may be thwarted by external pressures to devote themselves to others. These external pressures may become internalized and female clergy may feel guilty for attending to their health.

In addition, institutional efforts to bolster the social support of female clergy may be beneficial. The creation of an alternative setting in the form of a cross-denominational support network for female clergy may help waylay fears of vulnerability that exist with denominational peers and circumvent concerns about confidentiality.

The identification of health challenges encountered by local church pastors may constitute a unique contribution to the literature, as health among this group is understudied. However, because local pastors often serve rural churches, it is impossible in the current study to disentangle the effects of local pastor status and rural living status (Miles, A., Proeschold-Bell, R. J., & Puffer, E., 2011). Thus, the local pastor findings reported here may be attributable to a larger group of clergy serving in rural areas.

Local church pastors reported health challenges resulting from financial limitations. Appointments for local pastors in the UMC are made depending on the needs of the conference and are more likely to be part-time with a lower salary. The financial strain reported by local pastors may contribute to feelings of decreased control and self-efficacy over one's health behaviors. Local pastors may believe that they need more financial resources to initiate healthy behaviors like exercise, nutritious diets, and mental health services. Increased salaries for local clergy may constitute a health intervention, but may not be a feasible solution. At a minimum, mental health benefits should be strong so that local church pastors are able to access counseling. Policy changes that encourage use of regular time off and vacation time could be instituted. To

augment social support, financial support for yearly family retreats could be considered, as could cross-denominational clergy support networks.

One strength of local pastors that this study revealed is their use of friendship networks and social support. This suggests that the health behaviors of local pastors' friends and family are vitally important. If the norm of their support system members is to engage in healthy behaviors, then it is more likely that local pastors will too. At the same time, local pastors voiced strong pressure from congregants for pastors to always be working and available. This expectation would be considered in the Integrated Behavioral Model as an injunctive norm or stated norm that pastors should put others ahead of themselves. Young pastors are also an important group to support; between 1985 and 2008, the proportion of UMC elders younger than 35 years of age decreased from 15% to 5%. Much like local church pastors, young pastors reported financial barriers to health and may benefit from similar financial support. Additionally, PPRCs, which are responsible for mediating relationships between the pastor and the laity of the parish, may be recruited to serve as advocates for the health of young clergy by helping to educate congregants about clergy health needs.

Young pastors expressed concern about stigma for health problems. They may hold a normative belief that most clergy are not seeking stigmatized care, such as mental health care, and this may decrease their intention to seek care. In contrast, for physical health, young pastors exhibited greater awareness of physical health needs and taking care of themselves. They may view the norm of eating unwholesome foods as a norm for people who are slightly different from them, like congregants, and may therefore be able to maintain healthy eating habits.

Young pastors' increased awareness of health issues and recognition of churches as a potential venue for health interventions present an opportunity for improving the health of congregations and other pastors. Some church health interventions, such as creating church gardens, may benefit congregant health while simultaneously address some of the young pastors' financial barriers to healthy food. Establishing active lifestyle and healthy eating norms within the church environment may be broadly beneficial.

Clergy may also be able to influence social norms and stigma surrounding mental health issues (Mattox, 2008). Because they are attuned to the health needs of congregants, young clergy may be more willing to acknowledge and accept this role. The awareness and enthusiasm for health improvement and maintenance expressed by young clergy may be particularly useful in a connectional system like that of the UMC. Young clergy may be able to serve as peer educators by helping other pastors negotiate healthy behaviors in a demanding role.

The health-protecting strategies utilized by pastors of larger churches may inform interventions that improve the health of other clergy. Large church pastors indicated that they have the skills to set boundaries to manage their workload in a way that did not come across for any other group. Thus, if large church pastors intend to engage in a health behavior, they may be more likely to follow through and protect their time. The ability of large-sized church pastors to set boundaries and take personal time shows that clergy successfully implement health-improvement strategies under certain conditions. Other clergy may benefit from encouragement

to take personal time off by the institutional hierarchy as well as by their large-sized church peers. Perhaps pastors could be empowered to take fifth Sundays off earlier in their career, a strategy reported by clergy at large churches. Alternatively, a lesson from large-sized church pastors may be that a system of "on call" pastors is needed to alleviate the strain of being responsive to congregants constantly.

The data appeared to convey a shift in thinking between young and large-sized church pastors. Young pastors expressed undergoing efforts to figure out where their sources of support are, and when they can garner support from district superintendents. They seemed to view the institutional environment as a constraint on their health-seeking behaviors, for fear of consequences if they reveal health problems. In contrast, large-sized church pastors viewed their clergy peers and the UMC institution as a source of support, which may represent an environmental support for health behaviors. With institutional support, it may be possible to assist in creating this shift in thinking sooner in one's clergy career.

Each subgroup expressed concern about the lack of "safe" venues in the conference for clergy to admit their vulnerability and seek help for mental health issues. The language that each group used for the stigmatized class of issues was different. Women pastors felt constrained from admitting "emotional problems." Young pastors used the terms "mental illness" and "depression." Large church pastors spoke of the risks of "overwork" and "burnout." This observation may give some insight into the different perceptions these groups have of the health risks inherent in ministry work, or of the corporate culture in the UMC.

The qualitative nature of this study allows for a more thorough understanding of the facilitators of, and barriers to, health by clergy subgroups. However, it does not allow us to determine the degree to which these facilitators and barriers exist. The study is also limited to one Christian denomination, although there are many similarities between the kinds of work and stressors experienced by clergy across denominations (United Methodist, Baptist, Pentecostal, Lutheran, Presbyterian, Episcopalian, and United Church of Christ denominations, as well as Catholic priests; Carroll, 2006; Dewe, 1987; Frame & Shehan, 1994; Gleason, 1977; Kay, 2000; Kuhne & Donaldson, 1995; Noller, 1984) spanning numerous geographic locations (United States, England, Wales, Hong Kong, New Zealand, and Australia). Because of these cross-denominational similarities in clergy tasks and experiences, we believe that this study's findings are likely to be relevant across denominations. For example, the pressure from congregants for pastors to make themselves constantly available has been expressed across denominational studies (Blanton & Morris, 1999; Ellison & Mattila, 1983; Hall, 1997), as is the bias against women in clergy that leads female pastors to overwork to prove themselves (Frame & Shehan, 2005; Glover-Wetherington, 1996).

In contrast, clergy salaries do vary. Clergy in Protestant denominations in connectional ministries with central authority, such as Episcopalians, Methodists, and Lutherans, earn more than clergy in Protestant denominations with congregational or local church autonomy, like Baptists and Pentecostals. Catholic priests earn less than Protestant clergy (McMillan & Price, 2003). Thus, Protestant pastors in congregational denominations and Catholic priests may

experience even more financial strain than reported here. Also, the UMC is rather unique in the fact that bishops appoint UMC clergy to churches, which gives bishops and district superintendents substantial power over clergy lives. In other denominations, churches typically interview and "call" a pastor to serve at their church. For this reason, pastors in non-UMC denominations may be less hesitant to reveal their health problems to peer pastors and may benefit from greater peer support, because of less fear that their peer pastors will someday supervise them.

This study is limited by the small number of participants in the female, local, young, and large church focus groups, meaning that there were a limited number of experiences for comparison across groups. Although the sample sizes for our groups were small, our findings are validated by other studies that have found similar results (Kessler, Chiu, Demler, & Walters, 2005; Rayburn et al., 1986).

Conclusions

In spite of these limitations, this study deepens our understanding of occupational stressors experienced by clergy and how these stressors relate to health practices among subgroups of clergy. This study builds on a small but growing literature concerned with health promotion among these important societal leaders, many of whom serve as social change agents. Community psychologists can use this enhanced understanding to determine how to affect the health of pastors, which may, in turn, affect the health of their congregants. Future clergy health intervention studies should include observation of congregation members. Such studies may inform community psychologists about the interplay between societal leaders and their communities, and thus yield lessons for health promotion for large numbers of people.

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