

The Resilience of Clergywomen?: Gender and the Relationship between Occupational Distress and Mental Health among Congregational Leaders

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Religious leaders face unique vocational challenges that place their mental health at risk. As the clergy as a profession has traditionally been male-dominated, clergywomen experience greater occupational stress than their clergymen colleagues, putting their mental health at additional risk. However, past research offers varied evidence on the gendered nature of clergy health, suggesting that clergywomen may be especially resilient to some difficulties of clergy work. Using panel data from the Clergy Health Initiative, a sample of United Methodist pastors from 2010 to 2021, this study examines clergy-specific occupational stress and its gendered relationship with depression. I find that, while clergywomen experience higher levels of occupational stress, the relationship between occupational stress and depression is weaker for clergywomen as compared to clergymen. This study thus offers a new perspective on the gendered nature of the pastorate: that clergywomen may be able to more effectively cope with vocational difficulties than clergymen.

Keywords: clergy, depression, gender, mental health, occupational distress.

INTRODUCTION

Religious leaders in the United States face unique vocational challenges. They enact varied and complex roles, they work in a relational space in which they offer substantial and generally unidirectional support, and they do all of this in a very public and sometimes critical atmosphere. These challenges create an atmosphere of vocational strain and stress associated with mental health problems (Carroll 2006; Knox et al. 2005; Proeschold-Bell et al. 2014). Although this stress and corresponding mental health risk are features of all clergy vocational experiences, clergywomen are likely especially at risk. The occupation of clergy has been cast as “sacredly male” (Bock 1967), and thus clergywomen may experience higher levels of stress and vocational struggles than their clergymen colleagues. Though we would expect this to correspond to worse mental health outcomes for clergywomen as compared to clergymen, past research offers mixed evidence on the gendered nature of clergy mental health (Hybels, Blazer, and Proeschold-Bell 2018; Jones, Francis, and Jackson 2004; Proeschold-Bell et al. 2013), with some research demonstrating that

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the mental health of clergywomen may not be affected by the difficulties of the pastorate at the magnitude expected based on past research.

This study seeks to better understand this potential resilience of clergywomen in the context of occupational distress and mental health. Using data from statewide surveys of clergy in the United Methodist Church (UMC) in North Carolina conducted by the Clergy Health Initiative from 2010 to 2021, I examine occupational stress among clergy and how gender moderates the relationship between that stress and depressive symptoms. I find that, while clergywomen experience higher levels of occupational distress, the relationship between occupational distress and depression is slightly weaker for clergywomen as compared to clergymen. Building on past research that establishes the difficult and gendered work environment that clergywomen function within, this study focuses on the ways in which clergywomen, perhaps unexpectedly, may be able to cope more effectively with vocational difficulties than men. I hope this study begins to reorient the scholarly discussion on the gendered nature of the clergy, such that being a clergywoman may be conceptualized as potentially congruent with the role of the clergy, and as potentially a strength and asset.

BACKGROUND

Clergy as a Vocation Prone to Mental Health Risk

Leaders of religious congregations hold unique vocational positions in U.S. society. Parishioners trust that clergy work comes from a religious calling, and thus that the primary vocational motivation is to fulfill divine will. Though this could produce additional job satisfaction for clergy, it also could create additional stress because of the risk of failing their call (Pargament and Mahoney 2005; Stewart-Sicking et al. 2011). In addition, clergy have highly complex jobs, as they fill a variety of professional roles, including administrator, manager, counselor, preacher, community organizer, spiritual director, teacher, and crisis responder, resulting in a fragmented work schedule and little personal time (Carroll 2006; Chatters et al. 2011; Kuhne and Donaldson 1995; Lee 1999; Morris and Blanton 1994; Pickard and Guo 2008). One outcome of these varied and unpredictable demands on their time is high levels of occupational distress and low levels of engagement in self-care activities (Kay 2000; Rowatt 2001; Hang-yue, Foley, and Loi 2005; Proeschold-Bell et al. 2012).

Even though clergy work is distinctly interpersonal, many studies have found that clergy report few people they can confide in or turn to for social support (Morris and Blanton 1994; Rowatt 2001; Weaver et al. 2002; Carroll 2006). Alternatively, one study did find that clergy do name a fair number of supportive individuals when asked to do so on surveys, but at the same time they report lower perceived support, possibly because they expect high-quality support like they give others (Eagle, Hybels, and Proeschold-Bell 2019). Furthermore, many clergy experience financial strain because of relatively low compensation for their work (Rowatt 2001; Carroll 2006; Proeschold-Bell et al. 2012). Despite gains in earnings over the recent decades, clergy experience an immediate wage penalty upon entrance into this profession, a penalty that is greater for clergy working in parish ministry than for clergy working in other settings (Schleifer and Chaves 2016). Therefore, despite its interpersonal nature, clergy work takes place in a context with low social support, alongside high expectations, the attainment or lack of achievement of which (spiritually, emotionally, and professionally) are on display (Gleason 1977; Morris and Blanton 1994; Rowatt 2001; Carroll 2006; Miner 2007). However, despite these difficulties, clergy well-being exists in a tension, as clergy consistently report high levels of vocational satisfaction even as they report feeling persistent stress and vocational difficulties (Rowatt 2001; Carroll 2006; Stewart-Sicking et al. 2011; Stewart-Sicking 2012).

Because of the distinctive nature and difficulties of their work, clergy are at a unique mental health risk. Clergy have been documented to have higher rates of depression as compared to the general population (Flannelly et al. 2002; Knox, Virginia, and Lombardo 2002; Knox et al. 2005; Proeschold-Bell and LeGrand 2010; Proeschold-Bell et al. 2013). In addition, clergy report a reluctance to seek mental health care or divulge mental health struggles, indicating that they are less likely to receive needed help to improve their mental health (Proeschold-Bell et al. 2012).

Clergy Health and the Stained-Glass Ceiling

Leadership of religious congregations remains a male-dominated occupation (Sullins 2000; Reedy-Strother 2011). Women have moved into these positions of authority within religious congregations at a much slower rate than similar status positions in other areas of society (Bock 1967; Chaves 1996; Hoge 2011), leading some to posit a “stained-glass ceiling” in religious organizations (Purvis 1995). Though approximately half of U.S. Protestant denominations ordain women, and over half of all American religious congregations report that in principle a woman could serve as the sole or senior pastoral leader of the congregation, these policies have not translated to the realities of congregational hiring practices (Chaves 1996; Hoegeman 2017; Chaves et al. 2021; Lauve-Moon 2021). Between 1998 and 2018, the percentage of congregations whose solo or senior leader was a woman increased only 3 percentage points, from 11 to 14 percent (Chaves et al. 2021). Though this marginal increase may indicate some level of change in certain sectors of the religious landscape, research has demonstrated that, as women do move into the pastorate (sometimes referred to as the “feminization of the clergy”), this often serves to bolster the status of men in the profession, rather than to establish the position of women (Nesbitt 1997).

A primary reason that the share of women in lead ministerial positions has not increased in recent years may be that some religious traditions view congregational leaders as definitionally masculine because God has ordained the role as ontologically or “sacredly” male (Bock 1967). In a vocation that is centered on the subjective experience of a “calling,” the fact that clergywomen are often seen as theologically errant likely has an additional negative effect on mental health for these women. Furthermore, as one study of focus groups of pastors found that pastors tend to understand their mental health and spiritual well-being as interwoven and indistinguishable (Proeschold-Bell et al. 2011), the experience of having their spiritual calling questioned because of their gender may have both negative spiritual effects and negative mental health effects.

Though the difficulties of the pastorate apply to all clergy, clergywomen experience them in a gendered way. For example, though low levels of compensation affect all clergy, most research has found that clergywomen are paid less than clergymen, even when controlling for related factors, such as the size of congregation, type of ministry, geographic location, and age of the clergy person (Finlay 1996; Zikmund, Chang, and Lummis 1998; McDuff and Mueller 2002; Hoge 2011; Schleifer and Miller 2018). In addition, clergy who serve struggling or shrinking congregations experience higher levels of stress than those serving larger or more organizationally stable congregations (Miner 2007)—a fact that is notable as clergywomen are more likely to be hired by smaller and struggling congregations (Lehman 1987; Finlay 1996; Zikmund, Chang, and Lummis 1998; Konieczny and Chaves 2000; McDuff 2001; Adams 2007; de Gasquet 2010; Hoge 2011; Chaves and Eagle 2015; Hoegeman 2017).

Furthermore, while it is well-documented that clergy who experience low levels of social support have worse mental health (Knox et al. 2005; Carroll 2006; Proeschold-Bell et al. 2014), this is also experienced in a gendered way. One study found that clergywomen perceive lower levels of social support and experience greater demands on their time (Miles and Proeschold-Bell 2012). Other research on the gendered experiences of clergy seems to support these findings. For example, in addition to their official and multifaceted vocational roles, parishioners often expect clergywomen to carry out certain gender-stereotyped tasks, such as cleaning the parsonage or the church building (de Gasquet 2010). Furthermore, when clergymen and clergywomen enact

the same occupational duties, their congregations evaluate clergywomen less favorably (Charlton 1987; Maybury and Chickering 2001; Eagly and Karau 2002). As high levels of demand and low levels of support are associated with higher levels of negative mental health for clergy (Proeschold-Bell et al. 2014), these clergy are likely more at risk.

Therefore, based on the theoretical and empirical evidence that clergywomen experience greater stress and barriers in their careers, we would expect that clergywomen would exhibit worse mental health. However, past research has produced mixed evidence. For example, Jones, Francis, and Jackson (2004) found no significant differences in anxiety levels between clergymen and clergywomen. More importantly, these authors found that, while clergymen had significantly higher anxiety than men in the general population, clergywomen had significantly lower levels of anxiety than women in the general population. Furthermore, despite the fact that women in the general U.S. population are more likely than men to experience psychological distress and be diagnosed with depressive disorders (6.6 percent of women compared with 4.4 percent of men), this relationship was not borne out in a large sample of clergy, in which clergymen and clergywomen demonstrated similar rates of depression (8.2 percent of clergywomen compared with 8.8 percent of clergymen) (Proeschold-Bell et al. 2013). In contrast to these findings, other research using latent class analysis found that clergywomen are more likely to be in the classification with high depressive symptoms than clergymen (Hybels, Blazer, and Proeschold-Bell 2018). Taken in sum, past empirical evidence does not produce definitive evidence on the status of clergywomen's mental health and well-being. Thus, despite the documented difficulties that clergywomen face in their careers and the gender differences in mental health at the national level, clergywomen do not seem to be uniformly manifesting the negative outcomes that we would expect.

Among the past work that has found that—contrary to expectation—clergywomen do not demonstrate worse mental health than clergymen, researchers have stayed almost unanimously silent on the reasons why this may be happening. One reason is that many clergy samples do not have substantial enough representation of women to conduct valid analyses of the effects of gender. For example, Proulx (2008) found that clergymen have substantially higher rates of depression than clergywomen, but the sample only included two women, limiting the conclusions that the author could draw from this finding. As a result, very few authors either explicitly discussed possible theoretical reasons for gender differences in mental health (or lack thereof) or directly examined the mechanisms empirically. Eagle and colleagues (2019) found that clergywomen turn to more people for social support, and Kansiewicz and colleagues (2022) found that clergywomen are more likely to seek professional treatment for mental health than clergymen. Hybels and colleagues (2018), in their use of latent class analysis, found that women were more likely to be found in the class with the highest rates of occupational stress and the lowest rates of social support. However, in all of these analyses, gender was not a main measure of interest and therefore their results were not thoroughly explored or theorized. Thus, though the theoretical reasons why clergywomen should demonstrate worse mental health are clear, the mechanisms at play for why clergywomen do not demonstrate those expected outcomes are relatively unexplored.

The Current Study

The current study seeks to better understand the way that the gendered difficulties of the pastorate affect the mental health of clergywomen. I focus on one aspect of the pastoral vocation: occupational distress arising from interpersonal relationships and interactions with congregants. Using 11 years of longitudinal data collected on UMC pastors in North Carolina by the Clergy Health Initiative, I investigate how gender moderates the relationship between this form of occupational distress and depressive symptoms among clergy. I focus on depressive symptoms as my outcome of interest, as past research has highlighted its unexpected relationship with gender among clergy. I then explore reasons why the moderating relationship may exist.

DATA AND METHODS

Data

I used data from the Clergy Health Initiative Statewide Panel Survey of United Methodist Clergy, a longitudinal study of all UMC clergy in North Carolina from 2008 to 2021. For my analysis, I used six waves of data: 2010, 2012, 2014, 2016, 2019, and 2021. The number of participants per wave ranged from 1469 to 1802, with response rates ranging from 73 to 95 percent. I excluded retired clergy and clergy who were in extension ministry positions outside of traditional congregational leadership, such as working as a chaplain or in denominational administration, to establish greater homogeneity in the occupational stressors experienced by the sample. Pastors in congregational leadership positions made up at least 70 percent of each sample wave. All procedures were approved by the Duke University Institutional Review Board, and all participants gave free and informed consent.

The UMC is a beneficial sample to use for studying clerical differences by gender. First, the UMC has been ordaining women for over 60 years, with women making up over a quarter of UMC clergy in North Carolina for at least the past 15 years. Second, in 2021, one third of UMC clergy in North Carolina were women, mirroring the percentage of head clergy who are women in mainline congregations nationally (Chaves, Holleman, and Roso 2022). Therefore, focusing on the UMC offers the opportunity to have a substantial sample size of women clerics, while holding analyses stable within one theological tradition and organizational structure. However, focusing on a sample of UMC clergy does limit analyses, as the organization is very racially homogeneous and has been studied as a case of a racialized organization (Eagle and Mueller 2022). For this analysis, non-white pastors made up between 8 and 13 percent of the sample per study wave, which made it almost impossible to conduct meaningful analyses between racial groups other than white and non-white. However, this sample is appropriate to understand the gendered patterned of clergy health within white mainline denominations—the only prominent religious tradition in which at least a quarter of head clergy are women (Chaves, Holleman, and Roso 2022).

Measures

The outcome measure in this study was individual depression scores, measured by the Patient Health Questionnaire-8 (PHQ-8) (Kroenke et al. 2009). This measure consists of nine items that measure the frequency of depressive symptoms in the past 2 weeks, ranging from “0” (not at all) to “3” (nearly every day). These nine items inquire if the respondent is experiencing little interest or pleasure in doing things; feels down, depressed, or hopeless; has trouble falling or staying asleep, or is sleeping too much; feels tired or has little energy; has poor appetite or is overeating; is feeling bad about him or herself, or that he or she is a failure or has let his or herself or family down; has trouble concentrating on things, such as reading the newspaper or watching television; and is moving or speaking so slowly that other people have noticed, or is so fidgety or restless that he or she has been moving around a lot more than usual. Responses are then scored additively, and possible PHQ-8 scores range from 0 to 24, with higher scores indicating a greater number of depressive symptoms. In addition, individuals with PHQ-8 scores equal to 10 or greater qualify respondents as likely to be moderately-to-severely depressed. In my initial exploratory analysis, I use this cutoff ($\text{PHQ-8} \geq 10$) to better understand the basic patterns in the data. In the multivariate model, I use the numerical PHQ-8 scores to investigate the basic patterns in more detail. Because of the skewed nature of these scores, all regression models were run with the natural logarithm of PHQ-8 as the outcome variable. As some respondents had a 0 score, a value of 1 was added to every respondent's score before computing the natural logarithm.

The independent variable in this study was the Clergy Occupational Distress Index (CODI) (Frenk et al. 2011). The CODI is composed of five questions that measure the frequency with which clergy experience occupational distress, ranging from “0” (never) to “3” (very often). The five items are: “During the past year, how often have the people in your congregation made too many demands of you?”; “During the past year, how often have the people in your congregation been critical of you and the things you have done?”; “Looking back over the past year, how often have you experienced stress as a result of dealing with congregational members who are critical of you?”; “Over the past year, how often have you felt lonely or isolated in your work?”; and “Over the past year, how often have you experienced stress because of the challenges you have in this congregation?” Responses are then scored additively, and possible CODI scores range from 0 to 15, with higher scores indicating greater distress.

Gender was the moderator variable of interest. From 2010 to 2016, the response options were limited to “male” and “female.” This was expanded to include “other” in 2019 and 2021. I excluded from this analysis any individuals who identified with a gender other than “male” or “female” in 2019 or 2021, or who did not specify their gender in any wave ($n = 7$). This group was too small for meaningful analysis.

I controlled for a range of demographic and ministry characteristics: race, a dichotomous measure of whether the respondent is white or not; age upon entry into the panel survey; marital status, a dichotomous measure of whether the respondent was married at the time of data collection; and education, a dichotomous measure of whether the individual has a master’s degree or higher. I include these measures as past research has demonstrated that non-white individuals, married individuals, older individuals, and individuals with higher education exhibit better mental health (Kessler et al. 1992; Link and Phelan 1995; Kim and McKenry 2002).

I also controlled for conditions of the clergyperson’s ministry: the rurality of the congregation the pastor served, a dichotomous measure of whether the parish is located in a town or village with a population of 10,000 people or less; the number of hours worked per week in their current position; and the number of years the person had worked in ministry upon their entrance into the panel survey. Past research has demonstrated that rural clergy face a greater number of stressors that they are required to handle alone (Miles and Proeschold-Bell 2012), clergy who work longer hours demonstrate worse mental health (Eagle, Hybels, and Proeschold-Bell 2019), and clergy with more years of experience in ministry exhibit worse mental health (Proeschold-Bell et al. 2013).

Finally, I also controlled for two coping mechanisms that respondents reported engaging in. First, a measure of help seeking behaviors, operationalized by a dichotomous variable indicating whether the respondent had ever in his or her life seen a mental health professional for the treatment of depression, anxiety, or stress. Second, a measure of the social resources that the respondent felt he or she had access to, operationalized by the respondent’s answer to the question “how socially isolated do you feel?” If the respondent answered “extremely,” “very,” or “moderately” socially isolated, he or she was coded as socially isolated. Past research has demonstrated the importance of professional and personal social support for individual’s mental health (Muñoz et al. 2012; Lutz and Eagle 2019).

Statistical Analysis

The analysis for this study was twofold. First, I used a cross-sectional analysis to examine the relationships between depression, occupational distress, and gender in the sample of clergy in each of the six waves of the study. This allowed me to establish the levels of occupational distress and depression in the population of North Carolina United Methodist clergy, and assess if, cross-sectionally, gender moderated the relationship between occupational distress and depression. Second, building on the cross-sectional analysis, I examined the relationships among

Table 1: Description of study sample at baseline, 2010

| Baseline characteristic | Total sample (N = 1440) Mean (SD) or % (n) | Clergymen (N = 1058; 73.5%) Mean (SD) or % (n) | Clergywomen (N = 382; 26.5%) Mean (SD) or % (n) | Gender difference p-Value |
|--------------------------------------|---|---|--|-------------------------------------|
| <i>Variables of interest</i> | | | | |
| PHQ-8 score | 4.06 (4.21) | 3.92 (4.13) | 4.46 (4.38) | .030* |
| Depressed status | 10.17% (146) | 9.66% (102) | 11.58% (44) | .289 |
| CODI score | 6.28 (3.11) | 6.03 (3.09) | 6.97 (3.09) | < .001*** |
| <i>Demographics</i> | | | | |
| White | 91.17% (1311) | 91.48% (966) | 90.31% (345) | .493 |
| Age | 52.92 (11.05) | 53.54 (11.23) | 51.18 (10.35) | < .001*** |
| Married | 88.00% (1272) | 94.00% (991) | 74.00% (281) | < .001*** |
| Master's degree | 78.68% (1133) | 79.02% (836) | 77.75% (297) | .604 |
| <i>Conditions of ministry</i> | | | | |
| Years in ministry | 15.82 (11.97) | 17.64 (12.53) | 10.79 (8.43) | < .001*** |
| Hours worked/Week | 46.28 (14.53) | 46.44 (14.58) | 45.85 (14.40) | .494 |
| Serves rural parish | 55.05% (790) | 55.36% (584) | 54.21% (206) | .701 |
| <i>Coping resources</i> | | | | |
| Ever seen mental health professional | 39.68% (571) | 34.63% (366) | 53.66% (205) | < .001*** |
| Feels socially isolated | 29.57% (424) | 27.00% (284) | 36.65% (140) | < .001*** |

Source: Clergy Health Initiative Statewide Panel Survey of United Methodist Clergy, 2010

Notes: **p* < .05; ***p* < .01; ****p* < .001.

depression, occupational distress, and gender longitudinally, using a hierarchical linear mixed-effects regression model. This allowed me to test whether the within-person relationship of a change in occupational distress and a change in depressive symptoms was moderated by gender.

Missing data were handled in two ways. For the two scales of the PHQ-8 and CODI, if the respondent answered at least half of the items making up the scale, the remaining missing items were imputed with the mean of the answered items. This was done during the curation of the data by Clergy Health Initiative analysts. Using the curated data, less than 3 percent of each individual variable used in my analysis was missing. Furthermore, in the regression analysis, almost all (96 percent) respondents had valid values for all the relevant measures. Because of the low levels of missingness, I employed listwise deletion on the cases with missing values.

RESULTS

Summary statistics at the 2010 baseline are presented in Table 1. Ten percent of the sample reported depressive symptoms indicating moderate-to-severe depression (PHQ-8 ≥ 10, hereafter referred to as “depression” or “depressed status”). This is slightly higher than rates in the general population, which is about 7 percent (Pratt and Brody 2014). This is in line with past research, which found that religious clergy are at above-average risk of depression (Proeschold-Bell et al.

2013; Lutz and Eagle 2019). In terms of occupational distress, the sample had an average score of 6.26 on the CODI at baseline, similar to scores reported in a national validation study (Frenk et al. 2011).

The respondents were largely white (91.2 percent) and predominantly male (73.5 percent). The representation of clergywomen increased to a third of the sample over the six waves of the study (32.8 percent in 2021). In 2010, the clergy were predominantly married (88.0 percent), highly educated (78.7 percent of the sample had a master's or doctoral degree), and were 52.9 years old, on average. The average clergyperson in the sample had been working in ministry for 15.8 years and worked an average of 46.3 hours per week. Over half (55.1 percent) of the sample served a rural congregation. In addition, the sample demonstrated relatively high levels of help seeking behaviors, as over a third of the sample (39.7 percent) had ever seen a mental health professional. This was alongside of relatively high experiences of social isolation, as 29.6 percent reported feeling at least moderately socially isolated.

Table 1 also describes the demographic differences between clergymen and clergywomen. Clergywomen had significantly higher levels of occupational distress than clergymen ($p < .001$). They also scored, on average, approximately a half of a point higher than men on the PHQ-8 (4.46 vs. 3.92; $p < .05$)—a small but statistically significant difference. However, clergywomen were about as likely to be categorized as depressed as clergymen (11.58 percent for women vs. 9.66 percent for men). This difference was not statistically significant ($p = .289$). It is interesting that the gender difference in depression is not larger, as clergywomen in this sample were younger ($p < .001$), less likely to be married ($p < .001$), and had worked fewer years in ministry than their clergymen counterparts ($p < .001$). Clergywomen were also much more likely to have seen a mental health professional at some point in their lives ($p < .001$) and much more likely to feel socially isolated ($p < .001$).

Table 2 shows the main effects of occupational distress and gender on number of depressive symptoms, without accounting for demographic factors, conditions of ministry, or coping resources. Without accounting for any other factors, occupational distress was a consistent statistically significant positive predictor of depressive symptoms, across all six waves of data ($p < .001$ for all models). Interestingly, after accounting for occupational distress, the coefficient for gender was significant in only two of the six waves ($p < .05$ in 2016; $p < .01$ in 2021). In both waves, being a woman predicted a higher number of depressive symptoms. When adding the interaction term between occupational distress and gender into the model, the interaction term was significant and negative in three of the six waves ($p < .01$ in 2010; $p < .05$ in 2012; $p < .05$ in 2019). In 2010 and 2019, both gender and the interaction between gender and occupational distress were statistically significant. This indicates that women exhibited more depressive symptoms when occupational distress equals zero, and that as occupational distress increased, the increase in depressive symptoms was smaller for women than for men.

Table 3 shows the results of the six cross-sectional linear regression models examining the relationships among gender, occupational distress, and depressive symptoms in each individual wave of the data, adding the control measures including demographic factors, conditions of ministry, and coping resources. When looking at the predictor of interest in the full model, the interaction term between occupational distress and being a clergywoman, the coefficient was negative and statistically significant in 2010, 2012, and 2019 ($p < .01$; $p < .05$; $p < .05$, respectively). In 2014, 2016, and 2021, the interaction term was negative but was not statistically significant.

Though occupational distress was a consistent predictor of depressive symptoms in every wave of the cross-sectional models, some demographic, ministerial, and coping controls also displayed statistical significance in at least one wave. First, in 2010, 2012, 2014, and 2019, white pastors reported more depressive symptoms than pastors of color ($p < .001$, $p < .001$, $p < .01$, $p < .01$, respectively). Second, in 2014, older pastors reported fewer depressive symptoms ($p < .05$). Third, in 2012, 2014, and 2016, and 2019, controlling for other factors, pastors who worked more hours per week exhibited fewer depressive symptoms ($p < .01$, $p < .05$, $p < .001$, $p < .05$,

Table 2: Cross-sectional linear regression models predicting number of depressive symptoms (logged), using linear regression

| | <i>Coefficient</i> <i>(std. error)</i> | <i>Coefficient</i> <i>(std. error)</i> | <i>Coefficient</i> <i>(std. error)</i> | <i>Coefficient</i> <i>(std. error)</i> | <i>Coefficient</i> <i>(std. error)</i> | <i>Coefficient</i> <i>(std. error)</i> |
|-------------------------------|---|---|---|---|---|---|
| | 2010 | 2010 | 2010 | 2012 | 2012 | 2012 |
| Intercept | 0.460*** (0.044) | 0.460*** (0.045) | 0.392*** (0.007) | 0.408*** (0.043) | 0.410*** (0.044) | 0.351*** (0.051) |
| Occupational distress | 0.132*** (0.006) | 0.132*** (0.006) | 0.144*** (0.007) | 0.140*** (0.007) | 0.140*** (0.007) | 0.151*** (0.008) |
| Woman | - | -0.004 (0.045) | 0.289** (0.107) | - | -0.011 (0.044) | 0.185 (0.098) |
| Occupational distress × Woman | - | - | -0.043** (0.014) | - | - | -0.031* (0.014) |
| <i>N</i> | 1418 | 1418 | 1418 | 1370 | 1370 | 1370 |
| <i>R</i> ² | .236 | .236 | .240 | .249 | .249 | .251 |
| | 2014 | 2014 | 2014 | 2016 | 2016 | 2016 |
| Intercept | 0.453*** (0.044) | 0.448*** (0.045) | 0.399*** (0.052) | 0.376*** (0.045) | 0.356*** (0.045) | 0.326*** (0.053) |
| Occupational distress | 0.136*** (0.007) | 0.135*** (0.007) | 0.144*** (0.008) | 0.147*** (0.007) | 0.145*** (0.007) | 0.150*** (0.009) |
| Woman | - | 0.025 (0.045) | 0.191 (0.099) | - | 0.105* (0.045) | 0.200* (0.099) |
| Occupational distress × Woman | - | - | -0.027 (0.014) | - | - | -0.016 (0.014) |
| <i>N</i> | 1259 | 1259 | 1259 | 1230 | 1230 | 1230 |
| <i>R</i> ² | .247 | .247 | .249 | .271 | .274 | .274 |
| | 2019 | 2019 | 2019 | 2021 | 2021 | 2021 |
| Intercept | 0.618*** (0.051) | 0.599*** (0.053) | 0.523*** (0.062) | 0.625*** (0.051) | 0.592*** (0.052) | 0.537** (0.061) |
| Occupational distress | 0.118*** (0.007) | 0.118*** (0.007) | 0.130*** (0.009) | 0.124*** (0.007) | 0.122*** (0.007) | 0.131*** (0.009) |
| Woman | - | 0.070 (0.051) | 0.303** (0.111) | - | 0.137** (0.051) | 0.313** (0.111) |
| Occupational distress × Woman | - | - | -0.037* (0.016) | - | - | -0.027 (0.015) |
| <i>N</i> | 975 | 975 | 975 | 935 | 935 | 935 |
| <i>R</i> ² | .207 | .207 | .211 | .242 | .247 | .249 |

Source: Clergy Health Initiative Statewide Panel Survey of United Methodist Clergy, 2010–2021.

Notes: **p* < .05; ***p* < .01; ****p* < .001.

respectively). Fourth, in 2021, pastors who served a rural congregation reported more depressive symptoms (*p* < .05). Finally, the two measures of psychological coping resources were significant predictors of depressive symptoms in all six waves. Pastors who had ever seen a mental health professional reported more depressive symptoms (*p* < .001 for all six waves), as did pastors who felt socially isolated (*p* < .001 for all six waves). Taking all other factors into account, marriage status, education, and the number of years spent in ministry were not significant predictors of the number of depressive symptoms.

Returning to the interaction between gender and occupational distress in their relationship with depression, Figure 1 shows the predicted PHQ-8 score of depressive symptoms for each wave of data by gender and occupational distress, holding all controls at their means. In all these figures, at the lowest levels of occupational distress, clergymen experienced fewer depressive

Table 3: Cross-sectional linear regression models predicting number of depressive symptoms (logged), using linear regression—Including demographic, ministerial, and coping controls

| | 2010 <i>Coefficient</i> <i>(std. error)</i> | 2012 <i>Coefficient</i> <i>(std. error)</i> | 2014 <i>Coefficient</i> <i>(std. error)</i> | 2016 <i>Coefficient</i> <i>(std. error)</i> | 2019 <i>Coefficient</i> <i>(std. error)</i> | 2021 <i>Coefficient</i> <i>(std. error)</i> |
|---|---|---|---|---|---|---|
| Intercept | 0.408* (0.166) | 0.254 (0.164) | 0.656*** (0.162) | 0.568*** (0.166) | 0.701*** (0.183) | 0.408* (0.185) |
| <i>Predictors of interest</i> | | | | | | |
| Occupational distress | 0.122*** (0.008) | 0.120*** (0.009) | 0.112*** (0.009) | 0.125*** (0.096) | 0.097*** (0.010) | 0.095*** (0.010) |
| Woman | 0.208* (0.105) | 0.138 (0.096) | 0.077 (0.095) | 0.143 (0.096) | 0.202 (0.107) | 0.178 (0.108) |
| Occupational distress × Woman | −0.041** (0.014) | −0.032* (0.013) | −0.021 (0.013) | −0.016 (0.014) | −0.031* (0.015) | −0.014 (0.014) |
| <i>Demographics</i> | | | | | | |
| White | 0.250*** (0.067) | 0.237*** (0.065) | 0.177** (0.066) | 0.128 (0.067) | 0.198** (0.073) | 0.035 (0.070) |
| Age | −0.001 (0.002) | 0.001 (0.002) | −0.005* (0.002) | −0.004 (0.002) | −0.004 (0.002) | −0.001 (0.002) |
| Married | −0.003 (0.063) | −0.002 (0.061) | 0.014 (0.061) | 0.079 (0.062) | −0.062 (0.066) | −0.024 (0.066) |
| Master's degree | −0.098 (0.055) | −0.028 (0.054) | −0.048 (0.056) | −0.038 (0.058) | −0.028 (0.062) | 0.122 (0.064) |
| <i>Conditions of ministry</i> | | | | | | |
| Years in ministry | −0.001 (0.002) | −0.001 (0.002) | −0.001 (0.002) | 0.001 (0.002) | 0.001 (0.003) | −0.001 (0.003) |
| Hours worked/Week | −0.003 (0.002) | −0.004* (0.001) | −0.004* (0.002) | −0.007*** (0.001) | −0.003* (0.002) | −0.001 (0.002) |
| Serves rural parish | 0.033 (0.040) | 0.002 (0.039) | 0.075 (0.040) | 0.038 (0.042) | 0.064 (0.047) | 0.113* (0.048) |
| <i>Coping resources</i> | | | | | | |
| Ever seen mental health professional | 0.242*** (0.041) | 0.214*** (0.040) | 0.296*** (0.041) | 0.275*** (0.043) | 0.290*** (0.048) | 0.239*** (0.050) |
| Feels socially isolated | 0.318*** (0.045) | 0.472*** (0.046) | 0.386*** (0.047) | 0.335*** (0.046) | 0.369*** (0.052) | 0.400*** (0.051) |
| <i>N</i> | 1418 | 1370 | 1259 | 1230 | 975 | 935 |
| <i>R</i> ² | .298 | .335 | .337 | .341 | .300 | .328 |

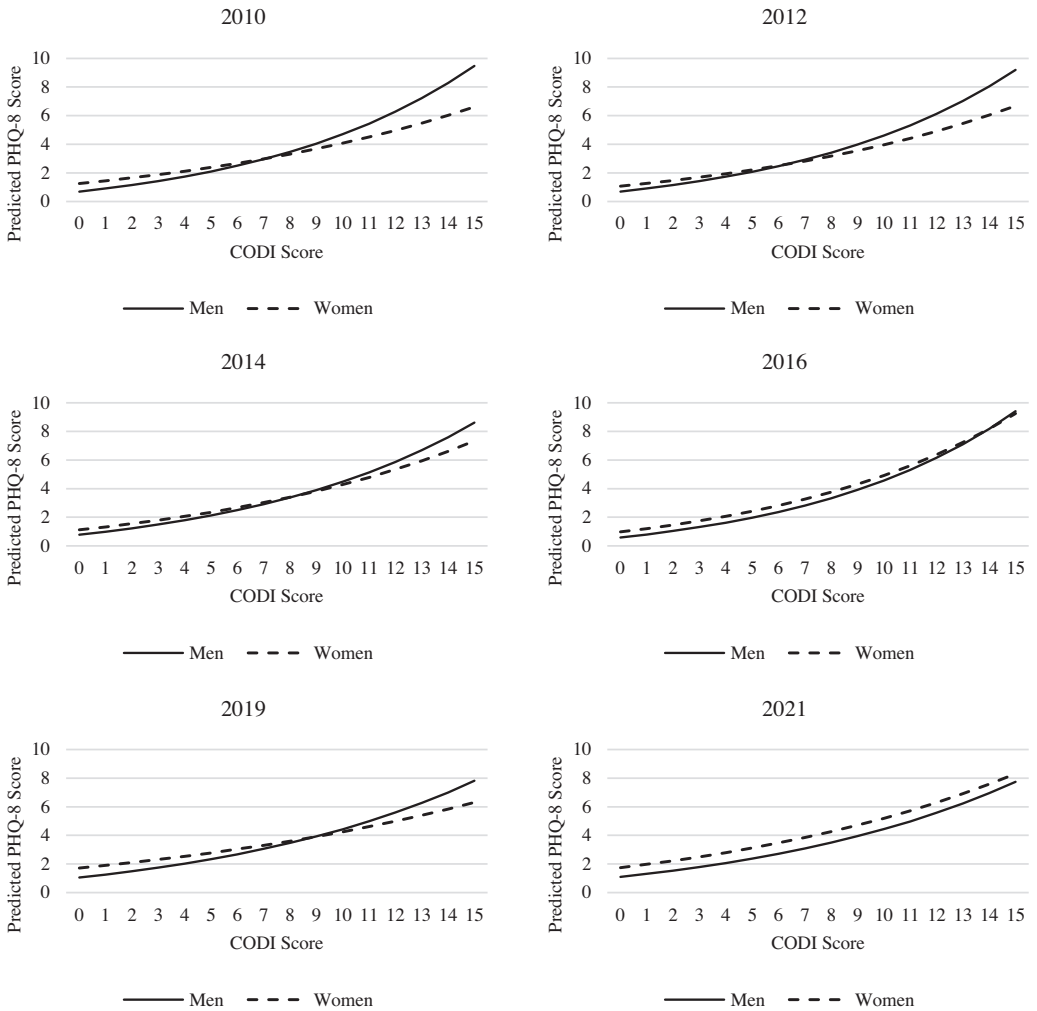
Source: Clergy Health Initiative Statewide Panel Survey of United Methodist Clergy, 2010–2021

Notes: * $p < .05$; ** $p < .01$; *** $p < .001$.

symptoms. However, in five of the six waves, as levels of occupational distress increased, clergywomen demonstrated smaller increases in depressive symptoms, such that at the highest levels of occupational distress clergywomen reported fewer depressive symptoms. However, these differences are fairly small, and even at the highest levels of occupational distress the advantages for clergywomen in PHQ-8 scores average 1.30. While a four-point difference in the PHQ-8 corresponds to a greater increase in depressive symptoms than going from “never” to “nearly every day” on a single depressive symptom, a difference of 1.30 is fairly marginal.

Table 4 shows the results of a linear mixed regression model that examines the relationship between within-person changes in depression symptoms and changes in occupational distress over time. In a similar manner to the cross-sectional models, increases in occupational distress

Figure 1
 Predicted Cross-sectional relationship between gender, occupational distress, and depressive symptoms, 2010–2021



Source: Clergy Health Initiative Statewide Panel Survey of United Methodist Clergy, 2010–2021.

Notes: Graphs were produced using the linear regression models in Table 3, holding model control variables at their mean values. The predicted PHQ-8 scores are transformed back into natural values from the logged values produced by the regression model.

were a significant and positive predictor of increases in depressive symptoms, whether or not controls are included in the model ($p < .001$). When only occupational distress and gender were included in the model, gender was not a significant predictor of changes in depressive symptoms. However, when including the interaction term between occupational distress and gender, the coefficient for gender was positive and significant, and the coefficient for the interaction term was negative and significant ($p < .001$ for both).

The final model includes the control measures for demographic factors, conditions of ministry, and coping resources. The positive and significant relationship between individual increases in occupational distress and depressive symptoms across waves remained significant, even when

Table 4: Linear Mixed-effects regression models predicting change in number of depressive symptoms over time, 2010–2021

| | <i>Coefficient (std. error)</i> | <i>Coefficient (std. error)</i> | <i>Coefficient (std. error)</i> | <i>Coefficient (std. error)</i> | <i>Coefficient (std. error)</i> | <i>Coefficient (std. error)</i> |
|---|---|---|---|---|---|---|
| Intercept | 0.594*** (0.031) | 0.587*** (0.032) | 0.555*** (0.027) | 0.639*** (0.077) | 0.686*** (0.087) | 0.648*** (0.083) |
| <i>Predictor of interest</i> | | | | | | |
| Occupational distress | 0.116*** (0.004) | 0.116*** (0.004) | 0.112*** (0.003) | 0.111*** (0.003) | 0.113*** (0.004) | 0.097*** (0.004) |
| Woman | | 0.035 (0.032) | 0.182*** (0.040) | 0.205*** (0.047) | 0.210*** (0.047) | 0.139** (0.046) |
| Occupational distress × Woman | | | −0.019*** (0.006) | −0.023*** (0.006) | −0.023*** (0.006) | −0.021*** (0.006) |
| <i>Demographics</i> | | | | | | |
| White | | | | 0.216*** (0.039) | 0.216*** (0.039) | 0.162*** (0.037) |
| Age | | | | −0.004*** (0.001) | −0.005*** (0.001) | −0.004** (0.001) |
| Married | | | | −0.076* (0.031) | −0.072* (0.031) | −0.035 (0.030) |
| Master's degree | | | | −0.006 (0.027) | 0.015 (0.029) | −0.032 (0.028) |
| <i>Conditions of ministry</i> | | | | | | |
| Years in ministry | | | | | 0.001 (0.002) | −0.001 (0.001) |
| Hours worked/Week | | | | | −0.002* (0.001) | −0.002** (0.001) |
| Serves rural parish | | | | | 0.046** (0.018) | 0.032 (0.017) |
| <i>Coping resources</i> | | | | | | |
| Ever seen mental health professional | | | | | | 0.236*** (0.022) |
| Feels socially isolated | | | | | | 0.271*** (0.019) |
| Study wave | −0.011* (0.005) | −0.011* (0.005) | 0.009*** (0.002) | 0.011*** (0.002) | 0.011*** (0.002) | 0.005* (0.002) |
| <i>N</i> | 7187 | 7187 | 7187 | 7187 | 7187 | 7187 |
| <i>Marginal R²</i> | .194 | .194 | .174 | .193 | .194 | .261 |
| <i>Conditional R²</i> | .576 | .577 | .573 | .580 | .577 | .579 |

Source: Clergy Health Initiative Statewide Panel Survey of United Methodist Clergy, 2010–2021.

Notes: Coefficients indicate average change in logged PHQ-8 score over time. * $p < .05$; ** $p < .01$; *** $p < .001$.

adding controls ($p < .001$). The central predictor of interest, the interaction term between gender and occupational distress scores, remained statistically significant and negative ($p < .001$). Gender was a significant moderator, even when controlling for central demographic characteristics and conditions of ministry which may have impacted the relationship between depression, occupational distress, and gender.

Other characteristics significantly associated with changes in depressive symptoms were respondent race and age, hours worked per week, working for a rural congregation, seeing a mental

health professional, and feeling socially isolated. White pastors and younger pastors were more likely to experience a larger change in depressive symptoms in relation to a change in occupational distress than non-white pastors and older pastors ($p < .001$ and $p < .01$, respectively). In addition, clergy who worked more hours per week in their positions exhibited a smaller change in depressive symptoms ($p < .01$). Furthermore, the coping resources that clergy drew on for support had a significant relationship with changes in depressive symptoms. Clergy who had ever seen a mental health professional demonstrated a greater change in depressive symptoms, as did clergy who felt socially isolated ($p < .001$ for both). In addition, the clergy in the sample appeared to be demonstrating slightly more depressive symptoms over time, as the relationship of study wave with increases in depression symptoms was significant in every wave at least at the $p < .05$ level.¹

Figure 2 illustrates the way that gender moderates the relationship between changes in occupational distress and changes in symptoms of depression, holding all other predictors constant at their mean. As Figure 2 shows, clergywomen demonstrated increases in depressive symptoms at lower increases of occupational distress. Thus, it appears that, specifically among clergy who experience high increases in occupational distress, clergywomen are exhibiting a fewer corresponding depressive symptoms than their clergymen counterparts, holding all else equal.

Taking the bivariate, cross-sectional regression, and longitudinal regression results in sum, four central findings emerge. First, occupational distress was the most consistent positive and significant predictor of depressive symptoms in this sample of pastors. Greater occupational distress corresponded to more depressive symptoms in all six of the cross-sectional models, and increases in occupational distress corresponded to increases in depressive symptoms in the longitudinal models. Second, being a clergywoman seemed to correspond to marginal-to-positive increases in depressive symptoms. This difference was evident in the bivariate relationships, and it remained present in two of the six multivariate cross-sectional models when not including the interaction term between occupational distress and gender. Third, the moderating effect of being a clergywoman on the relationship between occupational distress and depression also demonstrated marginal-to-negative increases in depressive symptoms. This effect was demonstrated in both the longitudinal model and three of the six cross-sectional models. Fourth, some demographic characteristics, conditions of ministry, and coping resources mattered for the instances of and changes in depressive symptoms. White pastors exhibited more depressive symptoms, younger pastors exhibited fewer depressive symptoms, clergy who worked more hours per week exhibited fewer depressive symptoms, clergy who had ever seen a mental health professional exhibited more depressive symptoms, and clergy who felt socially isolated reported more depressive symptoms.

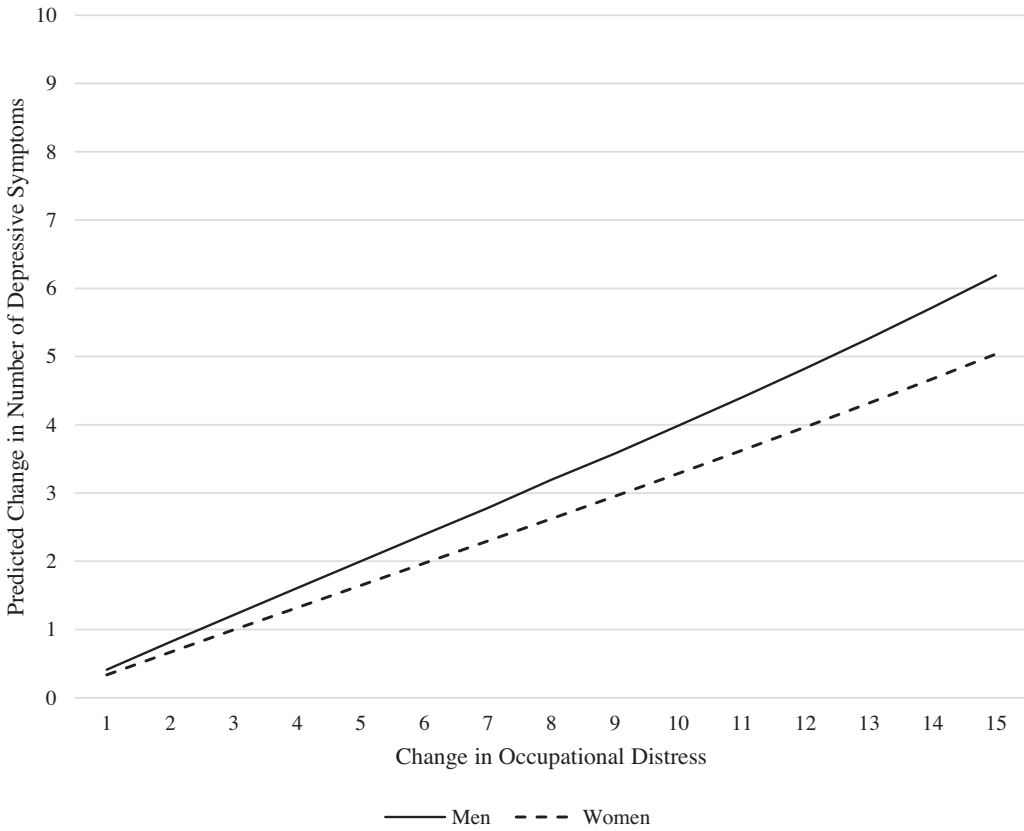
DISCUSSION AND CONCLUSION

Based on past research concerning the high levels of stress specific to being a clergywoman, compounded with consistent findings that women in the general U.S. population have higher levels of depression, clergywomen would be expected to have substantially higher rates of depressive symptoms than clergymen. However, I found that, while clergywomen do exhibit more depressive symptoms, this difference is not large enough to amount to a gender difference in depressed status. Furthermore, while clergywomen experience significantly higher occupational distress than clergymen, gender moderates the relationship between occupational distress and

¹Other versions of this model were run in which models interacted gender, occupational distress, and study wave, in order to examine if the way in which clergywomen process occupational distress and its relationship with depression changed over time. Study wave was not significant in any model, and thus it was left out of the final model.

Figure 2

Predicted relationship between change in occupational distress scores and change in number of depressive symptoms



Source: Clergy Health Initiative Statewide Panel Survey of United Methodist Clergy, 2010–2021. Notes: Predicted changes in PHQ-8 scores were calculated using the linear mixed-effects regression model in Table 4, holding model control variables at their mean values. The predicted PHQ-8 scores are transformed back into natural values from the logged values produced by the regression model.

depressive symptoms, such that occupational distress has a slightly weaker relationship with depressive symptoms for women than men. Though a slight effect, it appears that clergywomen may be coping with occupational distress in a more effective way than their clergymen counterparts.

I am not claiming to have shown definitively that clergywomen are more resilient than clergymen. The findings in this paper demonstrate a slight moderating effect of gender on the effects of occupational distress on depressive symptoms. When looking at the realities of the relationship between gender, occupational distress, and depressive symptoms in Figures 1 and 2, the statistically significant differences do not amount to large substantive differences. However, even a slight mental health advantage for women relative to men for a subset of clergy—those experiencing high levels of occupational stress—is surprising given past research and theory on gender differences among clergy. Furthermore, this finding presents important future steps for both theoretical and empirical investigation.

This relationship between gender, occupational distress, and depression among clergy may require scholars to reconceptualize the theoretical role congruence between the pastorate and

gender. Role congruence theory has been employed in the past to understand the ways that clergywomen experience discrimination as the pastorate is male-dominated (Ferguson 2018). However, the results of this study indicate that the relationship between the role of the pastorate and the congruence with being a woman may be more complicated. Though being a clergy person involves executive organizational leadership that is generally stereotyped as traditionally masculine (Koenig et al. 2011), many of the day-to-day tasks of the clergy may be more in line with social constructions of femininity. For example, pastors often functionally serve as caregivers, teachers, counselors, and social workers as part of their work (Kay 2000; Kuhne and Donaldson 1995), professions that are typically filled by women (Croft, Schmader, and Block 2015). Furthermore, when considering the particular places where the authority of the pastorate is given specific and special privileges in society, such as being able to visit the sick and dying in hospitals, this work is often distinctly interpersonal and emotional, and thus potentially in line with the stereotypical feminine (Shields 2002).

In line with this past research, the fact that the day-to-day tasks of the clergy may be more congruent with the stereotypically feminine may allow clergywomen to rebound more quickly from or to mitigate the damage from occupational distress experienced in their congregational work. Past research on women working in male-dominated fields found that these women coped with the difficulties of their profession by developing a distinct appreciation of their “feminine advantage” (Martin and Barnard 2013). The women in these studies strategically sought out and took advantage of areas in their careers in which stereotypically feminine styles of leadership would be advantageous, in a sense creating their own sense of role congruence amid the larger male-dominated structures. Clergywomen may in some ways be experiencing this “feminine advantage” simply through the communal nature of the responsibilities of the pastorate. The data used in this study could not directly address the day-to-day actions of the clergy in the sample, but future research could investigate pastor’s clerical duties “on the ground,” and the ways that these differ based on their congruence with traditional gender roles.

Another possible explanation is that women who are especially resilient select into male-dominated professions like the clergy. By the time the women in this sample of clergy became parish pastors, they had gone through seminary education, vocational training, and denominational screening. Because the clergy is often considered a role appropriate for men, women seminarians and ordinands experience greater barriers than their men counterparts, such as majority-men seminary faculty and masculine framing of theological concepts (Kleinman 1984; Stevens 1989; Adams 2007). In addition, even as higher rates of women have entered seminaries and pulpits in the so-called “feminization of the clergy,” this process often creates more resistance to the women who reach ministerial positions (Nesbitt 1997). The results of this are reflected in the fact that lower percentages of women seminarians go into congregational ministry than do men seminarians (Chaves and Eagle 2015). Thus, this often-difficult process of reaching parish ministry as a woman may ensure that the clergywomen in this sample may be especially equipped to preserve their traditionally feminine characteristics and adapt to the traditionally masculine characteristics required of them. Based on past research, preserving both agentic and communal styles of leadership seem to be congruent with the demands of the pastorate, and this may alleviate the mental health effects of the differentially gendered occupational distress from congregants. As this study was collected only after clergy had begun their careers, this analysis cannot speak to the process of selection into this profession.

In addition, this analysis suggests further research is warranted on the effect that demographic and occupational characteristics have on the lives of pastors. In many ways, the results presented in this paper reify the results produced by past research: namely, that white pastors, pastors working in rural areas, and pastors who feel socially isolated all demonstrate worse mental health. However, two notable results emerge. First, though past research has found that individuals who work more hours per week exhibit worse mental health (Proeschold-Bell et al. 2013), my models consistently showed that the number of hours worked per week showed a consistent and negative

relationship with the number of depressive symptoms. It may be that pastors who have full-time positions, and thus have greater job security and financial benefits, experience less stress and therefore better mental health. In addition, my models consistently showed a positive relationship between ever having seen a mental health professional and depressive symptoms. Though past research has argued that seeing a therapist and other mental health professional has positive benefits for mental health, it also seems clear that only individuals with a certain amount of depressive or other mental health symptoms would seek out this form of treatment. However, more research is needed on both of these fronts to fully understand the mechanisms involved in the lives of pastoral leaders.

These findings are not without limitations. This sample of clergy came solely from one predominantly white mainline denomination in one geographic location, the UMC in North Carolina. In 2021, representation of clergywomen in the UMC was almost twice the national average of all denominations combined. This indicates that this sample of clergywomen exists in an environment more welcoming to their presence than the average religious denomination in the United States, and that these clergywomen have a greater number of clergywomen peers than those working in other denominations. Both features of the sample could impact the results presented here. However, the high rate of clergywomen representation is what allowed these data to have a substantial enough sample of clergywomen to conduct this analysis, though the results may differ in other denominations that have not been ordaining women for as long as the UMC.

Furthermore, a shortcoming of almost all past research done on clergy health, in addition to the current analysis, is the lack of understanding of how these patterns may change or remain among non-Christian clergy. Future research should continue to investigate the ways the clergywomen may exhibit different pathways to mental wellness and struggle than their clergymen colleagues, specifically among different religious denominations and traditions. In addition, though the analyses presented in this paper focus on the occupational distress as the independent variable and depressive symptoms as the dependent variable, other research on clergy has analyzed the relationship in the opposite way (Milstein, Hybels, and Proeschold-Bell 2019). However, what is most important for the current study is the moderating role of gender in the relationship between depression and occupational distress.

This study offers a finding not usually presented in the study of religious leadership: that at least in some circumstances, such as experiencing high levels of occupational stress, being a clergywoman may be a strength and source of resiliency. Though clergywomen experience higher levels of occupational distress than clergymen, they appear to be able to cope with those stressors in a slightly more effective manner than clergymen, such that there is a weaker relationship between this stress and depressive symptoms for clergywomen. This study should encourage scholars to reconceptualize the gendered nature of the clergy, such that being a clergywoman may be a strength and source of resilience, rather than solely as a risk factor.

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