The Life of Leaders: An Intensive Health Program for Clergy

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Abstract

Clergy suffer from chronic disease rates that are higher than those of non-clergy. Health interventions for clergy are needed, and some exist, although none to date have been described in the literature. Life of Leaders is a clergy health intervention designed with particular attention to the lifestyle and beliefs of United Methodist clergy, directed by Methodist LeBonheur Healthcare Center of Excellence in Faith and Health. It consists of a two-day retreat of a comprehensive executive physical and leadership development process. Its guiding principles include a focus on personal assets, multi-disciplinary, integrated care, and an emphasis on the contexts of ministry for the poor and community leadership. Consistent with calls to intervene on clergy health across multiple ecological levels, Life of Leaders intervenes at the individual and interpersonal levels, with potential for congregational and religious denominational change. Persons wishing to improve the health of clergy may wish to implement Life of Leaders or borrow from its guiding principles.

Keywords: Clergy health, Health program, Intervention, Socioecological framework

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Introduction

Religion and health connect in many ways. The physical embodiment of this overlap occurs, to some extent, in the health and well-being of clergy. Studies on the standardized mortality rates of clergy have consistently found overall greater longevity among clergy due to fewer accidents and less suicide, smoking, and syphilis (Flannelly et al. 2002; King and Bailar 1969). However, those same studies show worse mortality rates among clergy due to chronic diseases such as heart disease and diabetes, which are on the rise in the United States (Hajjar et al. 2006; Mokdad et al. 2000; Neyer et al. 2007). Clergy are unlikely to be immune from the chronic diseases afflicting much of the United States. Indeed, a survey of all United Methodist clergy in North Carolina found alarmingly high rates of obesity, diabetes, asthma, and arthritis, when compared to their North Carolina counterparts (Proeschold-Bell and LeGrand 2010a). Yet, it is also possible that clergy will be difficult to convince to participate in health programming, because, despite these high rates of disease, they perceive themselves to have better physical health functioning than non-clergy (Proeschold-Bell and LeGrand 2010b). This disparity between clergy health self-perceptions and the objective data on the state of clergy health make careful con- sideration of clergy health programming important.

How to best tailor health interventions to clergy is an interesting question that requires an understanding of clergy lives. Religious leadership is a role rooted in paradox and tension, held between its explicit function on the boundaries of transcendence and nitty- gritty daily realities. Qualitative studies on clergy stress have found the following four categories of stressors: vocational stressors (inadequate pay, low work satisfaction, unrealistic time demands, relocation); intrapersonal stressors (emotional exhaustion, burnout, low personal satisfaction, sense of personal failure); family stressors (low family satisfaction, lack of family time, lack of privacy); and social stressors (high expectations regarding behavior, criticism, intrusiveness, lack of social support) (Rowatt 2001). Lee and Iverson-Gilbert (2003) conceptualized the antecedents of pastoral stress as personal criticism, boundary ambiguity, presumptive expectations, and family criticism. While coping with a lot of stress, clergy also experience high levels of vocational satisfaction, fulfillment and, indeed, even joy (Carroll, 2006; Stewart-Sicking 2009, October). Despite the unique aspects of clergy lives, we could not find a single journal article reporting on health interventions tailored to clergy. Through websites and phone calls, we were able to identify a number of clergy health programs, but information on them has not been made easily available to researchers or described with adequate depth to replicate (Wallace et al. 2010). Such description is necessary to facilitate the promotion of clergy health.

Proeschold-Bell et al. (2009) recently proposed a model of clergy health that categorized moderators of health into each of five levels drawn from a popular public health theory, the Socioecological Framework (McLeroy et al. 1988. Thus, rather than assuming that the health of clergy is determined solely by acts of individual clergy, the researchers propose multiple levels of influence: Intrapersonal, Interpersonal, Congregational, denomination-specific Institutional, and Civic Community. They concluded that clergy health is mediated by stress, self-care and coping

practices. Using this five-level model, this paper will describe a health program for clergy called Life of Leaders.

Understanding the process of developing a health program tailored to clergy is important. Such understanding may help health researchers develop interventions that are tailored to both faith and vocation. Second, readers may be interested in adapting and implementing the Life of Leaders intervention which is described here and directed by the Methodist LeBonheur Healthcare Center of Excellence in Faith and Health.

The Life of Leaders Program

Pre-Retreat Work

The Life of Leaders centers on a two-day executive physical and leadership development retreat. From the beginning, clergy are invited to participate in a caring, holistic manner, including receiving an invitation from our senior leadership and books and CDs that reflect an integrated approach to health. Prior to the retreat, clergy complete assessment materials that provide not only needed health information but also information on their spiritual and other strengths. Specifically, they complete Your Health Journey Narrative, the Values in Action Strengths Survey (Seligman 2002), the short version of the Myers-Briggs (Wennik 1999), and our own survey and health risk appraisal, which include information on spiritual strengths. We further obtain consent to receive primary care medical records dating back 5 years. We ask participants to help craft their experience in advance; we send them a form to indicate their top three picks from our ‘‘Concierge Service’’ (described below), and we inquire as to specific dietary needs and preference for a male or female physician.

Cohort Formation

For each retreat, we create a cohort of 10–12 clergy who share a commonality (e.g., all bishops or clergy of a denominational structure). Cohorts of like-minded leaders help decrease the isolation often cited in the literature that adds to clergy stress (Warner and Carter 1984). Also, the group experience allows participants to receive direct support from understanding clergy in an environment away from daily stress and potential work-related competition.

Life Practitioner Team

Prior to the retreat, we assemble a multi-disciplinary Life Practitioner Team, typically consisting of physicians, health coaches, dieticians, exercise physiologists, acupuncturists, massage therapists, and Pilates and yoga instructors. They function as a team, with horizontal, ongoing collaboration and communication in terms of assessment, interpretation and recommendations. They all understand the context of ministry life.

Permission-giving

In years of working in clergy health, we have observed that clergy often need to be ‘‘given permission’’ to ask for help or to support themselves. Clergy gain advance support for participating in Life of Leaders from their supervisors and congregations. This gives clergy the permission they need, as one participant said, ‘‘to allow me to be the ‘agenda’.’’

The Retreat, Day 1

To help clergy begin to attend to themselves, we have a Director of Hospitality who meets participants at the airport. In their hotel rooms, participants find gifts of healthy snacks like fruit, pretzels and nuts, and books on healing sermons (Morris, 2005) and the Leading Causes of Life (Gunderson & Pray, 2008). The first day of the retreat focuses on assessment. Phlebotomists come to the participants at the hotel to draw blood after fasting the night before. Participants receive a thorough physical exam, with at least 1-h face time with their physician. They also receive a full optometry examination, gross hearing screening, spirometry, chest X-ray, full chemical panel of bloodwork and EKG. Participants also undergo a 30-minute exercise and movement assessment that renders age and gender appropriate ratings in terms of functional muscle strength, flexibility, cardiovascular endurance, and range of motion, as well as percentage body fat and Body Mass Index. The data from this assessment dictate an individual’s ability to exercise safely and inform an exercise prescription. Participants further spend 45 min with a registered dietician, who reviews bloodwork findings, dietary data, chronic conditions, and family history and helps to develop an individualized eating plan. The individualized meeting often includes innovative tips for making better choices at congregational meals and eating healthier while traveling. Later, participants receive 90 min with a health coach who integrates spiritual and assets-based dimensions. The participant is allowed to choose topics and direct the discussion. After a break from Day One of Assessment, participants are escorted to a communal meal and interactive concert with a performer who both understands clergy and faith life and the Southern Delta nuances (to share our context of Memphis being the urban hub of the surrounding Delta area). This offers a well-needed reward from a full day of assessment and further extends the nuance of being cared for.

The Retreat, Day 2

The second day focuses on health discernment and enjoyment. Interpretive Sessions are held with the participant, physician, and health coach. During this session, hard copies of all records and findings are given to the participant, along with a two-page executive summary of integrated findings and the full team’s consolidated recommendations for enhancing health. Participants have ample time to ask questions and engage in interactive learning. The rest of the morning is filled with a personalized schedule of concierge services, the top three of which the

participants chose for themselves. Concierge services include acupuncture and/or complementary medicine consult, behavioral sleep consult, financial counseling, holistic pain management, massage, extended nutritional consultation, personal training for exercise, Pilates, Preventive Cardiology, therapeutic pool time, and yoga. Some offerings are in group format (Pilates, Preventive Cardiology), while some are individualized (holistic pain management, behavioral sleep). Lunch is provided in the Nutrition Demonstration Kitchen. A staff member with dual ''faith-health identity'' offers a ten-minute meditation on faith and health. Then, our health education staff prepares and teaches cooking healthy dishes, while participants partake of the meal. Menus are sent home with participants. After lunch, clergy participate in an interactive class on meditative prayer, learning to combine relaxing and meditative postures with prayer and scripture. The day ends with a debriefing session that challenges participants to think through ways that they can take their personal learning back to their respective work, congregations, or ministries. These dialogues tend to be innovative in terms of how to replicate parts of the Life of Leaders process on local ministry or organizational ground.

Post-retreat Check-ins

Life Practitioner Coaches conduct quarterly check-ins during the following year. A mid-year gift (e.g., a book from scholars at our Center of Excellence) is also sent with a follow- up letter, ideally around one of the church seasons. For example, one mid-year check fell before Christmas, so a poultry rub was sent as a pre-holiday reminder, with a realistic focus on ''staying the course'' and simply not gaining any weight over the hectic holiday season. Also, participants are encouraged to reach out to their Life Practitioners at any time. Participants often request local referral information.

Guiding Principles

Leading Causes of Life Framework

The Leading Causes of Life framework underlies all aspects of the Life of Leaders. This framework was developed by Gunderson and Pray (2006), who identified the following leading causes of life, admitting that they are not all-inclusive: (1) Connection or how you are in relationship to others within webs of trust; (2) Coherence or how you define the meaning of your life and tell your story; (3) Agency or the ability to do; (4) Blessing, an intergenerational focus on how we are in relationship with our ancestors and future generations; and (5) Hope. This Leading Causes of Life framework offers a language of life that moves past traditional biomedical views of pathology, psychopathology, and leading causes of death.

Holistic Health with Individualization

Our holistic health model examines physical activity, eating behaviors, spiritual well- being, and the context of clergy and leadership lives and roles. The team is led by the participant, not the physician. The participant ‘‘partners’’ with the health care team, who embody a holistic approach to enhancing quality of life for body, mind, and spirit.

Context of Ministry for the Poor

Life of Leaders partners with the Church Health Center (CHC), a comprehensive ministry for the underserved that seeks to reclaim the Church’s commitment to care for our bodies and our spirits. CHC offers four ministries: a primary care clinic, a health plan for the underserved, outreach to the faith communities, and a wellness center. Participants find that receiving care in a context of ministry for the poor demonstrates the intersection of faith and health in a manner not ever experienced before. While most executive physicals are delivered in state of the art, luxurious settings, with participants segregated from average life, people and services, Life of Leaders is embedded in this real-life ministry. One early participant described the context of this care delivery as follows: ‘‘The signs of the Kingdom are here in Memphis and at Hope and Healing. You see wholeness in community and diversity in the underserved community here and experience the real world of real people of all sizes, shapes, abilities, and ages not like the commercial health club where the young and fit dominate.’’ Many participants valued the parity and respect they saw demonstrated by staff in interacting with all. One description was ‘‘I felt like a Bishop who was being treated like a regular member, but was being treated like Royalty, as were all members served by your staff.’’

Clergy Leadership

Life of Leaders is a built-on language that reframes the subject of clergy health in a number of ways. Most obvious is that the experience is about the lives of clergy, not primarily about their current disease status. Secondly, it frames their primary role as a leader, not as a patient. Also, the experience tries to avoid simplistic clarity about the working life of the clergy as leader. We understand that the true task asked of clergy is transforming not just one’s own health or even that of one’s congregation, but rather that of the community. To do so requires numerous competencies that create a life of joy and strain in emotions, thoughts, and actions. Some of the many proposed competencies needed for community transformation are being present to the human and spiritual reality without fear, illuminating and supporting movement from self to social (and back), prayer, being with the poor, challenging the tyranny of externalities, appreciating the transformational potential of one’s faith tradition and open appreciation for others’ tradition, developing rituals of passage, growth, lament, and memory:

marrying, burying, graduating, counseling, lamenting, and celebrating. To one living outside the modern clergy life, this would appear to be an impossible collection of competencies. To one living inside that life, the language unveils the liquid complexity they are already experiencing. Life of Leaders does not focus on building the implied skill sets of those varied competencies, but on the way of life of the leader to promote the leader's health, and, relatedly, their ability to gain these competencies.

Fit With the Socioecological Framework

Now that we have described the Life of Leaders intervention and how it is tailored to clergy, we turn our attention to how the intervention intersects with the Socioecological Framework (SEF) theory. The SEF consists of five levels that influence health (McLeroy et al. 1988): Intrapersonal, Interpersonal, Community, Institutional, and Policy levels and has recently been used to create a model of clergy health (Proeschold-Bell et al. 2009).

The Intrapersonal level consists of an individual's beliefs and characteristics. Life of Leaders addresses Intrapersonal level conditions by having a participant complete their pre-work package and create his/her own program. We allow the participant a pathway to put their own needs and preferences first and to learn about their own physical health in great depth.

The Interpersonal level consists of relationships between the individual and key persons and small social networks, such as one's spouse, family, and close friends. Life of Leaders offers such support through (1) the Life Practitioner Team; (2) the cohort of clergy at the retreat; and (3) discerning with the clergy person ways to bring learning home to foster support locally.

The Community or Congregational level consists of shared identities, experiences, and resources for health. Life of Leaders offers specific tools around self-care issues in a congregational setting. For example, our dieticians teach discreet ways to eat more healthy foods and decline high fat or sugar foods offered at many church meals, along with strategies for eating more healthily while traveling or being feted at high-end restaurants or banquets. The Life of Leaders ''debriefing session'' offers strategies to help congregations understand pastors' roles and to help congregations change the common perception that clergy should be available at all times (Proeschold-Bell et al. 2009).

The Institutional level consists of rules, regulations, policies, and ethos that may promote or endanger health. While Life of Leaders cannot alter this level directly, we believe that as Life of Leaders becomes part of the culture of clergy leadership, some of the discernment process may ultimately impact institutional variables. For example, as participants experience Life of Leaders at a personal level, this may begin to alter expectations and perceptions that overwork is rewarded and that tending to emotional or mental health is important. Our hope is that Life of Leaders also may promote to laity, congregations, and pastoral care committees, the concept that clergy health practices are vital to ministry. Proeschold-Bell et al. (2009) also found that there was a reluctance to seek mental health treatment, for fear that it would impact negatively future appointments or salaries. Again, the Life of Leaders integrated model of clergy health offers

emotional and mental counseling that is grounded in positive psychology (not psychopathology). Proeschold-Bell and her colleagues suggested new models for itinerancy, in which clergy families could be allowed a month or so to ‘‘grieve’’ the losses in moving. Having clergy and spouses participate in the Life of Leaders’ process during such a major transition time would offer an ideal space within which the clergy could express their grief, engage in health practices, and bridge to their new appointment, while still discerning their overall health.

Future Study

The obvious next step for Life of Leaders is to conduct a rigorous outcomes evaluation. This evaluation should include process data to test the program’s fidelity to program components designed to impact the SEF levels. While the outcomes are unknown, early anecdotal data from the first set of participants from 2007 are promising. For example, one participant lost 40 lb, and several participants overcame the secondary anxieties associated with a prior heart attack and family history of cardiovascular diseases. A final testimony to the clinical utility of the program is that nine of those participants returned for a second Life of Leaders’ experience with their spouses in 2009, hoping to maximize the experience by sharing it with their significant other.

Both the Life of Leaders and the article on the clergy health model were specific to the United Methodist Church and its structure. Future Life of Leaders cohorts, conducted with participants from more diverse denominational structures, are needed to see how robust the process remains across different faith traditions. Funding for the program in its develop- mental stage was, and now continues to be, provided by the Center of Excellence in Faith and Health. In some select cohorts, religious foundation grant monies devoted to improving clergy health also subsidized costs of the program. The Center is currently exploring bundled insurance reimbursement for covering the costs of the interdisciplinary team providers who work with participants, as well as offering Life of Leaders for more traditional value-based leader cohorts funded by corporations, as potential sustainable business models. Life of Leaders health care professionals who understood the context of faith and health were selected and trained by the Clinical Director. In terms of provider reimbursement, 75% of the providers were paid staff at CHC and MLH, 20% (cardio- vascular, life coach and pain consultation) volunteered their time, and 5% were paid as hourly contractors (e.g., massage).

Conclusion

In the face of serious clergy health concerns, the dissemination of models such as the Life of Leaders is needed. The Life of Leaders offers a well-defined intervention designed to maintain and improve the health of clergy across multiple levels of the SEF. Our deep desire is that as the Life of Leaders discernment process filters from senior level champions throughout the denominational structures, clergy health behaviors will become the norm for a clergy and

congregational life. In turn, we expect that vitality, assets, strengths, and health will grow both in the individuals who experience the Life of Leaders process and in those they lead and serve.

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