Clergy Well-Being in The United Methodist Church: Twelve Findings from Surveys Across the Connection

Prepared for the *Center for Health*, General Board of Pension and Health Benefits of The United Methodist Church

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Using Data from the Following Sources:

The Church Benefits Association Survey of Clergy Health

The Duke Clergy Health Initiative 2008 Panel Survey of UMC Clergy in The North Carolina Conferences

The Virginia Conference of The United Methodist Church Wellness Survey

The UMC Church Systems Task Force Survey

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Executive Summary

As an overview on clergy health, information in this report is drawn from four data sources all arising from surveys completed with The United Methodist Church (UMC) clergy from 2006-2009. Constructs measured in one or more of these surveys include physical health (including indicators of chronic disease), emotional health (including markers for depression), spiritual vitality, job stress/demands, pharmaceutical claims, and contextual and demographic information.

Beginning with an historical and theoretical frame for the exploration of clergy health and following with three key findings from each source, this exploration of UMC clergy health provides an assessment of the current state of well-being (or lack thereof) among clergy across the connection. Building on the framework and findings, a discussion follows exploring the need for two major endeavors on the part of the larger Church—that of ongoing monitoring of clergy health in a representative and generalizable manner and secondly, the development, implementation and evaluation of intervention efforts to ameliorate negative influences or prevent their impact from the outset of a clergyperson's career.

In outlining the results below, they are presented in chronological order by survey administration period. The survey instruments contained anywhere from approximately 50 items (accounting for variables derived from responses) for the Church Benefits Association Survey collected during late 2006 and into early 2007 to over 400 items collected as a part of the Virginia Conference Health and Wellness Assessment in early 2009.

These are 12 key findings from the surveys—not an exhaustive exploration of every possible permutation or comparison possible among these sources. What I have aimed to do is pull together in one place points salient across the full population of UMC clergy. Subgroup comparisons are included where the information helps to clarify key points, but as with the full population, subgroups are not exhaustively explored herein.

Key Findings

Church Benefits Association Survey (2007):

1) Church attendance does not have the same apparent benefits for clergy that it does for laity.
2) With age, emotional health appears to improve, given a comparable level of stress and controlling for physical health.
3) Female clergy have higher stress and poorer physical health and they are more likely to be on psychotropic drugs than male clergy.

Duke Clergy Health Initiative Survey (2008):

1) UMC clergy in North Carolina experience higher rates of obesity, arthritis, hypertension, asthma, and diabetes than their non-clergy North Carolina peers, even after taking into account age, gender, employment status, and insurance status.
2) Body mass index and joint disease rates are higher among clergy serving churches in rural settings, although the prevalence of chronic health conditions does not appear to differ dramatically across parish setting (e.g., rural vs. non-rural).
3) Depression is prevalent among NC clergy. Overall, about 9% reported past two week depressive symptoms where the national comparison is about 6%.

Church Systems Task Force Survey (2009):

1) Thirteen factors emerge which are highly correlated with health, differentiating those who are healthy from those who are unhealthy.
2) Relocation associated with appointment changes has effects on family members and their well-being.
3) Intervention priorities are identified—specifically those which address the complex interaction between the clergyperson, their family, the congregation, and the institutional context in which they serve their call.

Virginia Conference Wellness Survey (2009):

1) As in the other surveys, we observe recognition among clergy of the burden of stress in their lives.
2) Retirement may positively influence health behavior and emotional outlook.
3) Clergy report that their spiritual life has positive effects in clergy well-being.

The 13 factors identified from the Church Systems Task Force Survey informed the work of the task force and guided its recommendations. Presented below (Table 1), these clergy health factors, when used in partnership with a socioecological model (Proeschold-Bell et al, 2009) and the findings from the four surveys, provide a framework to help guide monitoring and intervention to address UMC clergy health concerns across the connection.

Discussed in greater detail in the Church Systems Task Force Report (May 2011), several recommendations for improving clergy health emerge from this comparative review. Specifically, throughout the connection, efforts should be undertaken to:

- Offer programs to instill boundary awareness/maintenance and stress management;
- Develop vocational development/support programs with special attention to needs of female clergy, younger clergy, and ethnic minority clergy;
- Promote and provide support for mental health through a variety of means including pastoral counselors, life coaches, or spiritual guides;
- Educate bishops, cabinets, and SPRCs/PPRCs about the importance of time off/time away/taking Sabbath for clergy and their families; and
- Provide vocational mentoring throughout a clergyperson's vocation.

The United Methodist Church faces significant challenges in building healthy congregations and clergy. The data reviewed in this report identify where some of the most significant issues lie and provide a roadmap for monitoring and intervention.

Background

Beginning in 2006 and continuing through the next three years, several distinct efforts queried United Methodist clergy regarding their health and well-being. Each had a sample size of about 1000 respondents. Two queried national samples of UMC clergy and two were focused on clergy in two states in the Southeastern US (Virginia and North Carolina). Each evaluated to differing levels of detail:

- clergy job stress,
- physical health,
- emotional well-being,
- spiritual practices,
- social support, and
- financial matters.

Each effort used different sampling approaches, ranging from convenience (taking whoever responded) to a specifically drawn sample attempting to account for current health status to essentially a census of all active clergy within a defined population.

The first of the surveys involved querying clergy and laity from among denominations who were members of the Church Benefits Association (CBA) using a convenience sample. The second effort, the Duke Clergy Health Initiative (DCHI) involved 95% of active clergy within the two North Carolina conferences. Since the initial goal was to get all active clergy to participate, we can view this to be a census, meaning an enumeration of all active clergy within the North Carolina conferences.

In the third effort, data were collected from a national sample of 1000 active clergy as a part of the UMC Church Systems Task Force (CSTF). This sample was constructed using existing health risk status based on medical and pharmaceutical claims data for the 24-month period from January 2006 to December 2007 to ensure some of the least-well clergy were recruited to participate and thereby, help to avoid a bias that could be introduced if only the healthiest clergy responded.

Lastly, the Virginia Conference (VAUMC) undertook a very in-depth survey of clergy and their spouses. Here again, a census was attempted, this time including active

and retired clergy and their spouses. Result respondents would be characterized as a convenience sample, however.

Historical Context for Investigating Clergy Health

Traditionally, clergy have been characterized as one of the healthiest and longest lived occupational groups. In the late 19th century in England, Bertillon found that clergy had the lowest annual death risk and offered "the regularity, certainty, and fairly active life of the profession, doubtless explains this privileged existence" as quoted in a recent paper evaluating mortality among highly educated professionals (Erikson et al, 2009).

And while this may remain true for all causes of mortality considered in aggregate, clergy (particularly Protestant clergy) are one of the top ten occupations to die from ischemic heart disease (IHD). European-American clergy have an 11% higher death rate from IHD than their general population counterparts and African-American clergy have a 26% higher death rate from IHD (Calvert et al, 1999). And as job-related stress can be a significant contributor to the development of hypertension and hypercholesterolemia, both risk factors for IHD, this suggests evaluating stress among clergy may be informative in identifying risks and modifiable behaviors (Weaver et al, 2002). Moreover, screening for IHD risks among clergy may merit consideration (Flannelly et al, 2002).

A second study in Sweden suggests that clergy have an elevated risk of death when compared to other educated professionals (those with similar levels of education). Relative risk values of nearly 2 times that of the referent group of college professors were found for clergy (Erickson et al, 2009).

Although the US data regarding IHD are more than a decade old, our current survey results suggest that little has changed to reduce risk factors for IHD death among Protestant clergy, at least among those within The United Methodist Church.

Models of Clergy Health

When someone considers themselves to be well, most often this means they feel good physically—their physical health is intact. But other dimensions of well-being contribute to what we might call health. In the context of work within the *Center for Health* of the General Board of Pension and Health Benefits of The United Methodist Church, to physical health, we include an additional four components to round out the definition of health. These are: emotional, spiritual, social and financial well-being.

Emotional well-being encompasses mood, self-efficacy, self-image, etc.,—essentially one's viewpoint and confidence in oneself. Spiritual well-being centers on the relationship with God and the activities that support and enhance this relationship such as prayer, meditation, worship, etc. Social well-being considers the relationships within a person's life including support from friends and family. Last, financial well-being considers how well one is managing the business of living as well as preparing for retirement. While financial well-being is not often an element included in models of health, it is often a source of stress which can have major effects on multiple dimensions of health.

Each one of these components, when in their optimal state, helps to ensure the overall well-being and effectiveness of the human being. When one or more are impaired, the overall health and vitality of the individual suffers and their ability to thrive is diminished. In the case of a clergyperson, this imperils their ability to answer the call to serve God and their community. But what if the environment in which they respond to this call influences their ability to live vital and effective lives?

In considering another model of clergy health and well-being, that formulated by the Duke Clergy Health Initiative, we can find a socioecological framework for describing the impact of factors outside the individual on health. This ecological model places the individual at the core of a complex of contextual and environmental factors that can either enhance or impair health (Proeschold-Bell, et al 2009) and may be mediated by personal skills in coping and stress.

A third framework developed as a part of the work of the Church Systems Task Force is the list of 13 clergy health factors (Table 1). These factors summarize much of what was found through the survey. Informed by task force discussions and qualitative interviews, the net results place clergy health concerns in a broader context and provide a launching point for a discussion of intervention options to explore (see discussion below).

Combining the list of factors with the two models—that of five individual dimensions of health influenced by the physical, social, and cultural frame in which the individual exists—provides a useful approach for exploring the results of the surveys. The 13 factors provide a construct for considering implications across the four survey results.

Data Sources

As noted above, we worked with data from four different sources to draw conclusions about the health (broadly defined) of UMC clergy across the connection. All four queried active clergy while two of the four also included other respondents as a part of their original frame for inclusion. The CBA data included lay workers of the denominations that as members of the Church Benefits Association, agreed to participate in the survey. The VAUMC study included both retired and active clergy as well as their spouses. The common population across all of these sources is active clergy within the UMC. As such, most of the material presented here focuses on them—only where comparisons to the other populations (laity or spouses or retired clergy) provide additional insight into clergy health will we explore their responses.

Among active clergy, we have information concerning demographics, physical health and chronic disease, spiritual vitality and activity (including some measures of specific religious activity), their ministerial training experiences, contextual questions about the job of being a clergyperson in the UMC, self-assessment of the effects of their job on their own health and the well-being of their family members, job stress, the congregational environment and church characteristics, access to health care, their social and family support networks and pharmaceutical claims. All but the pharmacy claims information in the CBA survey were reported by the respondents themselves.

<u>Methods Summary</u>

Each data source was provided to the Duke Center for Spirituality, Theology and Health in a file format convertible for analysis. Combined with review of documents produced for each of the individual efforts, the approach was to focus on descriptive and associative results since in every instance the data come from cross-sectional samples. Without asking the same questions of the same people across time, assertions cannot be made about causation or a relative relationship across time. Descriptive measures like means and proportions help illustrate the overall nature of the sample and measures of association help facilitate understanding of the relative strength and

direction of relationship between an outcome variable (e.g., self-reported health) and other variables (which can either be elements for which we control—such as age, gender) or which we think have a relationship with the outcome variable (e.g., job stress).

Church Benefits Association (2007)

A mail survey was sent to a mix of clergy and laity in 2006 with the cooperation of member denominations and facilitation by the Church Benefits Association (an organization founded in 1915 and "dedicated to promoting excellence and preserving the traditions of church benefit boards and church benefits plans through nonpartisan education, collaboration and fellowship" (cited 10 April 2011 from http://www.churchbenefitsassociation.org/About/history.htm). The purpose of this survey was to investigate self-reported health and potential associations with religiosity, physical activity, social support, job stress, church characteristics, and demographic variables among both clergy and lay workers employed by the participating denominations. For a subset of workers, we were able to obtain pharmaceutical claims data from 2005 (the year prior to the time of the survey).

Administered through the mail, the survey was initially sent to 58,477 Individuals across ten denominations who were members of the Church Benefits Association. Overall, 11,123 responses were received. Among UMC participants, of an original contact pool of 40,948, responses arrived from 7,611 participants (18.6%).

Nine denominations permitted access to pharmaceutical claims data. Individual claims records were only accessed with the individual's consent. For the UMC, claims data were potentially available for 8,733 of which 1,375 responded to the written survey and provided consent for access of their claims data. Of those, 999 had complete records including claims data.

With the exception of comparing the relationship between church attendance and self-reported health between laity and clergy, laity, observations with values

missing for any of the variables used in modeling and observations without claims data were excluded in what is reported here.

While certainly not an exhaustive list of salient points, the three that are unique to the CBA survey are:

1) Church attendance does not have the same apparent benefits for clergy that it does for laity.

Lay church employees who generally reported regular church attendance had better self-reported health than clergy, who presumably spend much of their time in church and church-related settings. The finding of better health associated with church attendance is one of the oldest and most reported associations in the religion and health literature. The finding that clergy do not get this same "bounce" in health benefit is likely due to their time in church being work-related and not an opportunity for respite and renewal afforded to the parishioners.

2) With age, emotional health appears to improve, given a comparable level of stress and controlling for physical health.

While not a new finding across the emotional health literature, to confirm this in clergy suggests that with appropriate training, counseling and mentoring, there may be benefit to pairing younger clergy to older (possibly retired) clergy in the realm of stress reduction and coping skills. While mentoring programs already exist, how much they focus on emotional health tools and support remains unclear.

3) Female clergy have higher stress and poorer physical health and they are more likely to be on psychotropic drugs than male clergy.

Whether it is because their stress is truly greater or that their response is different, women clergy report higher levels of perceived stress. As women, however, in general, are more likely to seek medical care for concerns, it is not unreasonable to find that they have higher utilization of psychotropic drugs.

Duke Clergy Health Initiative Survey (2008)

A letter introducing a survey and telephone interview plan were sent to all active clergy in the two North Carolina Conferences in 2008. The purpose of this survey was to investigate self-reported health and potential associations with religiosity, physical activity, social support, job stress, church characteristics, and demographic variables among UMC clergy in North Carolina in preparation for a large initiative supported by The Duke Endowment investigating and intervening on clergy health.

Initial contacts of all active clergy (full and part-time clergy who were elders, district superintendents, bishops, deacons, extension ministers, and licensed local or student or retired pastors with church appointments) and were made by mail and phone. Appointments were made for completion of a phone interview by a third party research administrator, Westat, in contract with the Duke Divinity School. Of the 1820 active clergy contacted, completed interviews were obtained from 1726 for a response rate of 95%.

Questions from the Behavioral Risk Factor Surveillance Survey administered through the CDC and the NC State Center for Health Statistics were used on this survey which affords comparative opportunities with the general population in North Carolina and the US as a whole with respect to chronic disease risk factors and prevalence rates.

1) UMC clergy in North Carolina experience higher rates of obesity, arthritis, hypertension, asthma, and diabetes than their non-clergy North Carolina peers, even after taking into account age, gender, employment status, and insurance status.

North Carolina has significant health challenges, with high prevalence of chronic disease and associated risk factors (America's Health Rankings, 2011). So it is not surprising that as representatives of NC's population, the clergy responding to the DCHI survey present evidence [DELETE: of the some] of the same health concerns. What is concerning is that the rates are higher for many outcomes compared to the state as a whole, even when

adjusting for age, gender, employment status, and insurance status. Of particular note, only 25.4% of clergy reported being neither obese nor overweight, nearly 5 percentage points less than NC's general population (Proeschold-Bell, et al, 2010a). Without a reversal in rates of overweight/obesity, the associated risk for chronic diseases (e.g., cardiovascular disease, hypertension, and diabetes) and functional limitations (e.g., arthritis) will remain or increase. Efforts to build awareness and intervention are needed, particularly since UMC clergy possess "an optimistic view" of their physical functioning relative to their chronic disease burden (Proeschold-Bell et al, 2010b). Moreover, as stress is elevated among clergy and plays a role in chronic disease genesis independent of body mass, programmatic emphasis on stress mediation and reduction bear consideration as well.

2) Body mass index and joint disease rates are higher among clergy serving churches in rural settings, although the prevalence of chronic health conditions does not appear to differ dramatically across parish setting (e.g., rural vs. non-rural).

Over a third of clergy in the DCHI self-identified as serving a church "in rural or open country." Rates of high blood pressure, heart attack, and joint disease are higher among clergy serving rural churches than clergy serving non-rural churches, until you adjust for things that we know affect health, such as age, income, and education differences. Once adjustments are made, only joint disease remains significantly higher for rural-serving clergy. Body mass index is also higher among rural-serving clergy, and it, too, remains higher after adjustments. Overall, though, it is interesting that there appears to be little difference in health status for clergy by rural versus non-rural setting.

This is not the case for the general population, where rural status is associated with elevated risks of chronic disease incidence, mortality, and disability, even when controlling for age (Jones et al, 2009). It is likely that having access to health insurance may play a role here, making it easier for clergy to access health resources, even if they are not readily available in the community where they serve. Extrapolating this finding

to a national frame, we still really do not know if there may be rural/non-rural differences in outcomes or risk factors in other regions of the country or if differences may exist between those who live in suburban settings compared to inner city urban communities or rural communities. Nor do we have a clear understanding of how access (both in terms of resource availability and/or the comprehensiveness of insurance coverage) may influence outcomes across the population density gradient from rural to urban.

3) Depression is prevalent among NC clergy. Overall, about 9% reported past two week depressive symptoms where the national comparison is about 6%.

Among NC clergy, gender differences in depression prevalence are much less pronounced than in national measures (8.8% to 4.4% for men and 8.2% to 6.6% for women) which suggests common exposures placing clergy of both genders at similar risk (Smith, 2010). Several factors are related to an increased likelihood of depression and these include worse self-rated health, guilt about not doing enough, an elevated sense of social isolation, perceived financial stress, congregational criticism, personal doubts about one's call, and congregational demand (Proeschold-Bell RJ et al, 2010). While emotional health concerns may not be as prevalent as some of the physical health issues, as the body, mind and spirit are all connected, supporting a healthy mind helps to insure the availability of the pastor to serve. As such, programmatic support for the use of protective mental health such as counseling services and taking time off, all bear emphasis in any intervention effort.

<u>Church Systems Task Force Survey (2009)</u>

This survey was commissioned as a part of the work of the Church Systems Task Force in an effort to learn more about factors thought to influence clergy health and well-being and that are unique to the UMC system of ministry/itinerancy. The Church Systems Task Force undertook a complex research strategy to address these issues which included analysis of internal data held by the General Board of Pension and

Health benefits, focus groups, the quantitative survey discussed below, and subsequently, in-depth interviews with population of survey completers.

From the General Board of Pension and Health Benefits (GBOPHB) national database, 8,521 UMC clergy were included for the initial data analysis. Retrospectively, a health risk score was calculated for 6,681 using medical and pharmacy claim data for the period January 2006-December 2007. Where appointment data or data were missing along with those observations with fewer than seven months of claims history, these observations were eliminated. From the remaining 5,324, 3,922 were contacted for participation. The selection of this sample was weighted using the retrospective health score to ensure that 40% of the respondents were drawn from the lowest health tier (eliminating the risk that only health clergy would respond and thereby bias results). 1,006 completed the web-based survey (response rate of 28%). Through the initial internal data analysis and rounded out with input from the focus groups, the web survey sought to identify the strongest predictors of health from a wide-range of factors and to afford differentiation between those who were healthy and those who were unhealthy. The questionnaire addressed issues of personal background, appointment history, career trajectory/training, attitudes about ministry, congregational context, work stressors and coping, social support, job demands, living/working conditions, spiritual practices, leadership-style, finances, and demographics. For the analysis, health was a composite measure created from:

- Overall self-assessment of health, current and when entering ministry
- Limitations on vigorous physical activity
- Work limitations because of health conditions
- Disability status
- Energy level
- Emotional outlook
- Exercise habits
- Nutrition habits
- Sleep habits

- Body Mass Index (calculated from height and weight)
- Health risk score (from GBOPHB HealthFlex claims data)
- Heath Risk Assessment (HRA) score (from GBOPHB self-administered tool).

Using this composite score allowed exploration of what factors seemed to have the greatest relationship to good health relative to poor health.

1) Thirteen factors emerge which are highly correlated with health, differentiating those who are healthy from those who are unhealthy (See Table 1).

Taken as a group, these 13 factors identify: sources of stress (e.g., relationship with the congregation, stressors of the appointment process); challenges to maintenance of physical health (e.g., eating habits, work/life balance); challenges to emotional health (e.g., existential burdens of ministry, living authentically), impacts upon social health (e.g., marital and family satisfaction, outside interests and social life); the importance of spiritual health (e.g., personal centeredness); and the influence of finances, all of which have implications for how we design, implement, and evaluate interventions to reduce the gap between those who are in good health and those in poor health.

2) Relocation associated with appointment changes has effects on family members and their well-being.

Specific to the issues of relocation with appointment changes, 43% had had 2 or more moves greater than 30 miles away from the prior appointment within the last two years (the median number of moves for the whole sample was between 2 and 3 moves within ten years). And when asked to assess how they adjusted to moving to a new area, most (57.1%) felt they adjusted well (score between 0-4 on a scale of not at all difficult to extremely difficult that ranged from 0 through 10) but felt less so about how their family members adjusted (33.4%). Given that changing location of physical residence is known to be one of the most stressful of life events, it is not surprising that clergy suggest there

are challenges associated with moving on average about every 3 to 4 years. So the itinerancy produces stressful consequences for clergy and their families.

3) Intervention priorities are identified—specifically those which address the complex interaction between the clergyperson, their family, the congregation, and the institutional context in which they serve their call.

The thirteen factors are a tremendous asset when beginning to consider what issues merit intervention and at what level. Areas where intervention aimed at the system of itinerancy would be appropriate obviously include the stress associated with the appointment process and how that appears to affect health (the least healthy are about twice more likely to indicate a negative assessment of the process than those who are healthiest) and the challenges of relocation (34% of the least healthy had three or more appointment changes in the last 10 years compared to 22% of the most healthy). Individual behavioral interventions could focus on eating habits, physical activity, spiritual renewal, stress reduction and financial planning and management, among others. Interventions addressing relationships with the congregation would be another potential focus.

Table 1: Clergy Health Factors

- ***Personal centeredness*—**feeling a lack of control over one's life; ruminating about the past; difficulty experiencing the presence of God
- ***Eating habits with work that often involves food*—**struggling to maintain a healthy diet with food available at church meetings, social gatherings and home visits
- ***Work/life balance*—**having difficulty balancing multiple roles; feeling guilty taking time to exercise; avoiding health care because of time demands; struggling to achieve overall work/life balance
- ***Job satisfaction*—**feeling dissatisfied with one's appointments; feeling isolated at work; feeling disappointed with ministry; wishing for a way to exit the system
- ***Personal finances*—**high debt; low income; few assets; little to no personal savings
- ***Outside interests and social life*—**a lack of hobbies, outside interests and/or participation in group activities for personal renewal; having few friends or people with whom one can share personal issues; feeling detached from one's community
- ***Relationship with congregation*—**feeling judged rather than supported; feeling the congregation's expectations are too high or do not match one's own beliefs about the appropriate pastoral role; feeling the congregation desires a clergyperson with a different leadership style; avoiding relationships with congregation members so as to avoid improprieties; avoiding health care for fear that parishioners might find out
- ***Stressors of the appointment process*—**feeling stressed by the appointment process; feeling reluctant to talk to one's District Superintendent because of the power he or she holds over appointments; feeling resentful about being paid less than laypeople in similar professions
- ***Marital and family satisfaction*—**low marital satisfaction among clergy with families; low appointment satisfaction among spouses and/or children
- ***Existential burdens of ministry*—**feeling obligated to carry the weight of others' emotional and spiritual burdens; being overwhelmed by the needs of others and the sheer importance of the issues to be addressed in ministry; feeling expected to solve unsolvable mysteries
- ***Living authentically*—**feeling unable to be one's "authentic self"; failing to live according to deeply held personal values and beliefs
- ***Education and preparation for ministry*—**feeling unprepared by seminary for the everyday responsibilities of ministry; feeling one lacks the skills and training necessary to excel at pastoral duties
- ***Appointment changes and relocation*—**more frequent appointment changes; more frequent long-distance moves

Virginia Conference Wellness Survey (2009)

Very much like the NC study, this endeavor was intended to query all clergy within the Virginia Conference of the UMC, including those who were retired. Clergy spouses also were invited to participate. Of the 3280 members approached, 698 active clergy responded (response rate 57%), 160 retirees responded (response rate 28%) and 179 spouses of active clergy (response rate 19%) and 68 spouses of retired clergy responded (13% response rate) for an overall response rate of 34%. Conducted entirely online during the spring of 2009, the survey instrument contained information on family composition and responsibilities, ministry preparation and education, the vocational setting, leisure time and vacation, spiritual life and Sabbath time, social and emotional support, housing and community, health conditions, financial/legal concerns, appointments and the itinerancy as well as a profile of the respondents.

1) As in the other surveys, we observe recognition among clergy of the burden of stress in their lives.

This is especially apparent in responses to an open-ended question about top health concerns affecting clergy. To summarize, these include "…stress/burnout, time constraints/work load, lack of exercise, and obesity" (Reynolds, 2009). So in their own words, these Virginia clergy identify many of the same concerns we have seen in other sources.

2) Retirement may positively influence health behavior and emotional outlook.

The general open-ended responses to the survey suggest time for exercise is difficult to find; however, retired clergy (91%) and their spouses (86%) along with active clergy (87%) and their spouses (84%) reported regular participation in physical activity in the last month. This suggests that it is possible to make physical activity a regular part of one's schedule as a clergy person, although it may be easier to accomplish with greater schedule flexibility in retirement. And while both groups (active clergy/spouses and retired clergy/spouses) reported higher fruit and vegetable consumption relative to the

population of Virginia as a whole, retired clergy spouses reported the highest consumption of all. So it is likely that in retirement, people may pay closer attention to healthy habits. All clergy and spouses are likely to report being satisfied with their lives and are relatively similar in this assessment to those of the general population. However, among those 65 years and older, satisfaction with one's life exceeds that of the Virginia population within the same age group. This latter point echoes the finding in the CBA data that emotional health improves with age. The implication for these assertions is that programs focused on wellness need to extend into the years of retirement where there is likely receptivity to improving behavior and a greater likelihood of a positive outlook, both of which exist within a population at the greatest risk for suffering chronic disease impairment as they age. In other words, while it is obvious that active clergy need assistance and guidance in improving their health and well-being, the retired clergy (who generally remain on UMC conference health benefits in some form or another) are a population not to be overlooked.

3) Clergy report that their spiritual life has positive effects in clergy well-being.

Both retired and active clergy believe their spiritual life has positive effects on their physical, emotional and spiritual health. Women feel this more than men as do those who are older (45 and above). When considering two major aspects of their spiritual life, both active and retired clergy report a strong relationship with God, indicating frequently experiencing the presence and power of God in the ordinary, in close relationships, in their thoughts and feelings and seeing examples and signs of God's purposes in their ministry setting. Moreover, most clergy report positive health effects of a second aspect of their spiritual life, that of holy friendship or participation in a covenant group. Where they have or have had the experience of holy friendship or covenant group experience, they note a positive influence on their emotional and spiritual well-being.

In summary, across these four resources we find evidence of all of the components outlined in our discussion of models for clergy health. The measures varied

by survey and in many instances, we are able to assess clergy alongside the rest of the community and to determine priorities to improve the well-being of individuals. That we find evidence of the components in all of the sources means we may use the models going forward in designing and evaluating interventions which address different aspects of clergy health. Clergy can serve as a resource in the specific application of these models—whether it be in suggestions to supplement gym memberships, to educate congregations about job demands and to encourage (require) that clergy take time for renewal.

These models clearly also have a broader application to the health of the UMC denomination as a whole. All five of the dimensions we consider here for clergy have merit for congregants as well. In addressing clergy health, we should be mindful of ways to support this objective by championing the well-being of the population the cleric serves as well.

Framing Clergy Health Going Forward

Starting with the premise that human flourishing is ultimately a gift of a benevolent God; clergy who are called into the service of the faith should be able to flourish in responding to that call. In the UMC, the connectional framework among congregations, districts, conferences, and jurisdictions can be a catalyst for clergy well-being by examining and transforming policy and practice—in other words changing the environmental context in which clergy live and work.

Human flourishing, however, is greater than the environmental context. Human flourishing is deeper and broader than the "simple" frame of physical, emotional, spiritual, social and financial health as measured in the four source datasets. It is a dynamic state of being in which, on balance, no single aspect of health outweighs another and in which, environmental or contextual challenge can be absorbed and overcome. Health across each of the five dimensions results in a whole greater than the sum of its parts.

Support for clergy and their families accrues benefits derived from health stewardship. Imagine a flourishing, thriving clergyperson (male or female) who is:

1) Physically healthy in body as well as free from disease morbidity;
2) Emotionally sound and capable of withstanding the challenges of life and vocation;
3) Spiritually engaged (and congruent) and nurtured wherein faith provides a foundation for action;
4) Socially supported by family, friends, colleagues and congregation; and
5) Financially stable.

Realization of these states of well-being without adequate support is naïve—each dimension requires external resources. Consider:

- adequate support for dietary and physical activity change including opportunity for exercise and renewal;
- encouraged access to therapy resources without stigma;
- an engaged caring mentor who supports clergy questioning, growth and renewal;
- respect for family and consideration of impacts associated with the itinerancy upon spouse and children; and
- mechanisms to support financial responsibility and health from entry into seminary through retirement.

Clearly, this picture is the ideal. In this review of findings from four data sources, we can characterize, at least in part, how well the denomination as a whole is doing toward realizing clergy who are thriving with whole health. In short, the realistic portrait of UMC clergy includes many with chronic but perhaps reversible physical and emotional health concerns, who have less time and opportunity for self-care and spiritual growth than desired and who find the constraints of itinerancy to negatively impact the well-being of their family accompanied by financial burdens that challenge adequate debt management and long-term resource planning.

Hope Found in Work Underway

The Church Systems Task Force developed recommendations for modifying the employment systems and culture of the UMC that negatively impact clergy health. A copy of the Task Force report detailing its recommendations may be found at http://www.gbophb.org/health_welfare/cstf.asp. The Task Force specifically:

- examined itinerancy and the appointment-making systems and recommended improvements that support clergy health;
- examined and recommended improvements to supervisory systems;
- addressed processes for entering and exiting ordained and licensed ministry; and
- provided guidelines for sustaining a healthy work/life balance during ministry.

Additionally, within specific conferences, programs are under development that may prove useful in reducing the negative health impacts observed to date. In North Carolina, the Duke Clergy Health Initiative Spirited Life program (http://spiritedlife.org) has chosen to emphasize a theological approach based on incarnation and grace to encourage clergy to take care of their bodies. Programmatic components of Spirited Life include stress reduction, weight loss and ongoing monthly support (coaching) to help make changes permanent. Virginia Conference Wellness Ministries, Ltd. (www.VCWMinistries.org) is making extensive use of information collected in the Virginia survey to help guide its efforts to facilitate health and wellness among clergy and their families. Lastly, there are programs and clergy health studies from the *Center for Health* (http://www.gbophb.org/health_welfare/centerforhealth.asp). As programs and interventions are piloted and results shared, the successes can lead the way to tailor "what's working" for congregations, districts, conferences and jurisdictions. The efforts underway in addition to others through the *Center for Health* and organizations within The United Methodist Church hold promise for movement from the current status of clergy health toward the ideal: flourishing, thriving clergy and their families. This will no doubt link to healthy congregations as well.

Programmatic development, while absolutely the necessary response for The UMC to take after addressing system-wide concerns through the CSTF, is ultimately unlikely to succeed long term unless tools are implemented to afford denomination-wide monitoring of clergy health. The *Center for Health* is undertaking two efforts, neither yet under full implementation, which will provide data to accomplish this task. The first—called the *Healthy Dimensions Assessment* (HDA)—is intended to be a tool for use by clergy and lay workers and their spouses across their lifetime. Ideally initiating with entry into training but certainly something that can begin at any point in a career, this tool aims to be a hybrid between a health risk assessment tool and a self-monitoring record across the five dimensions of health affording participants with a way to track their own accomplishments with respect to risk and preventive behavior profiles. One way to think of this tool is that it goes long and deep throughout the career stages experienced by a given individual.

The second tool, the Clergy Health Survey, is an instrument developed through collaborative efforts of the Duke Center for Spirituality, Theology and Health, the Duke Clergy Health Initiative, Virginia Conference Wellness Ministries, Ltd. and the *Center for Health* within the General Board of Pension and Health Benefits. This instrument is informed by the work of the Church Systems Task Force (see link noted above) and the information collected and evaluated through each of the four survey efforts summarized in this report. The intent of this instrument is to provide an annual cross-sectional survey of active UMC clergy using a stratified sampling approach to assure adequate representation of women and ethnic minorities across the US annual conferences. The questions are in large part extracted from one or more of the surveys reviewed herein and have been selected with the idea of allowing for comparison to the prior surveys as well as the general US population.

The HDA has already received some pilot application with about 600 individuals (active and retired clergy and some respective spouses from eight annual conferences). These individuals not only have the opportunity to receive a report on their current status relative to healthy behaviors and risk reduction, but will continue to be able to

compare year-to-year results. While undergoing some revision to maximize its applicability and utility, the HDA is expected to remain a key component of CFH activity for years to come.

The CHS remains in planning stages at this point. The survey instrument has been completed along with very informal pilot tests. The principal challenge ahead has to do with securing funding to support the implementation. Advisory support remains intact from the collaborating organizations.

Recommendations

Discussed in greater detail in the Church Systems Task Force Report (May 2011), several recommendations for improving clergy health emerge from this comparative review. Specifically, throughout the connection, efforts should be undertaken to:

- Offer programs to instill boundary awareness/maintenance and stress management;
- Develop vocational development/support programs with special attention to needs of female clergy, younger clergy, and ethnic minority clergy;
- Promote and provide support for mental health through a variety of means including pastoral counselors, life coaches, or spiritual guides;
- Educate bishops, cabinets, and SPRCs/PPRCs about the importance of time off/time away/taking Sabbath for clergy and their families;
- Promote well-being of clergy families in concert with efforts to support clergy; and
- Provide vocational mentoring throughout a clergyperson's career.

The United Methodist Church faces significant challenges in building healthy congregations and clergy. The data reviewed in this report along with recommendations found in the Church Systems Task Force Report identify where some of the most significant issues lie and provide a roadmap for monitoring and intervention.

Conclusion

In 1778, John Wesley wrote in a letter to Alexander Knox:

> *"It will be a double blessing if you give yourself up to the Great Physician, that He may heal soul and body together. And unquestionably this is His design. He wants to give you … both inward and outward health"* (Knox, 1837, pg 12).

He was referring to the dynamic relationship involving God and humanity in the creation of health or human flourishing. And while his initial application may be focused on the individual relationship of Knox to God, there is collective interpretation available as well. On the personal level, for the clergyperson, this includes relationships involving the self (intrapersonal), friends/family (interpersonal) and communities (congregations, districts, conferences, jurisdictions), culminated by the culture in which they reside. Given this context and in socioecological model terms, direct and mediated effects (through self-care/coping and stress) upon health, Wesley's statement captures the desire God has for each person to reconcile with the best of themselves and the world around them. He is talking about human flourishing, which is a process and not an end in itself.

The United Methodist Church faces significant challenges in building healthy congregations and clergy, in fostering environments in which flourishing can grow. The data reviewed here give us some ideas where the most significant issues lie and provide a roadmap for monitoring and intervention. But this must include an awareness of, if not direct attention to, partnering congregational health with clergy well-being. Only within an environment where all members have a chance to optimize their health will the well-being of the UMC as a denomination be elevated. Elevated collective well-being has implications for the care and compassion The United Methodist Church can bring to the communities in which they exist and seek to thrive—and on the denomination's ability to make disciples of Jesus Christ for the transformation of the world.

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