

Clergy Health A Review of Literature

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Executive Summary

Clergy Health: A Review of Literature

Introduction and Scope

The health of any organization's workforce is important to its overall success and productivity. The church gets no religious exemption from this requirement. Just as many companies have begun to look more seriously at the health and well-being of their employees, many denominations also have begun to look at the health of the clergy that serve in their churches. Collecting and analyzing workforce health data has allowed many corporations to help their workers lead healthier and more productive lives, which can improve a company's overall success. Denominations, too, are beginning to see how focusing on clergy health might enhance their fruitfulness in spreading the good news of Jesus Christ.

Three criteria were used to determine which works would be included in the review:

1. Did the work involve primary research with clergy? Every effort was made to locate studies that asked clergy to provide specific facts, data, views, and opinions on their health and well-being.
2. Was the primary focus the emotional or physical health of clergy?
3. Is the work current, or at least the most recent available research on the subject?

Although the review focuses on clergy health research, other material (such as health guides, self-help materials, and other writings) were used to define the scope of the review.

Definitions and Theology

A comprehensive definition of clergy health and well-being supported by the literature includes, not only traditional medical indices of physical and mental health but also self-care practices and access to health care resources; supportive personal and professional relationships; balance and coping skills; positive attitudes and outlook; and a passion for ministry grounded in a robust spiritual life. All clergy health literature places the issue in a larger theological framework that views health from the perspective of a theology of ministry and God's ultimate intentions for creation.

Emotional Health

Emotional health is an important component of overall health and well-being. "Clergy work-related poor psychological health, stress, and burnout pose an increasingly serious problem for the leaders of denominations throughout the world, as the particular circumstances related to the spiritual and religious leadership in the community have a special unique dynamic." (Lewis 2007, 2)

Despite reporting high job satisfaction there are common complaints related to emotional health. Areas investigated under emotional health included job satisfaction, stress, pastoral demands, demands of family and self, and the age of entry into ministry.

Physical Health

Detailed studies focusing on the physical health of clergy are a relatively recent phenomenon. Mirroring the heightened concern for health in contemporary society, interest in the state of clergy health has increased in recent years. Several major U.S. denominations -- the Presbyterian Church (USA), the Evangelical Lutheran Church of America, the Episcopal Church, and The United Methodist Church -- have begun to look at the issue of clergy health, collecting data and developing strategies to address emerging issues. The review focuses on both lifestyle risk and medical risks that clergy face.

Conclusions

There are some patterns and themes that emerge from these statistics, findings, and studies. Six particular conclusions are worth lifting up for consideration.

1. Clergy health is a mixed picture. While there are some problem areas that clergy share with the general population (i.e. weight) and areas that need more research (i.e. medical issues), this should not obscure some of the hopeful aspects of the findings. In general, clergy report better health than the population as a whole and exercise more often. The available research shows that clergy smoke less, drink less, exercise more often, and take more safety precautions than the population as a whole. These habits provide The United Methodist Church with a solid foundation for efforts to improve clergy health.

2. Medical risks are present for clergy and need further study. While clergy do experience emotional health problems, evidence suggests that they are more prone to medical issues like blood sugar, blood pressure, cholesterol, and the like. While clergy may be doing better than the general population in some of these measures, there is less clear of a distinction here than there is on matters of lifestyle risk, such as alcohol and tobacco use. There is a lack of direct evidence on many of these concerns. Much more work is necessary to assess the physical health of clergy and to address the issues that emerge.

3. Clergymen and clergywomen differ in their level of health and their perceptions of health. This is shown to be true study after study. Some of the difference is biological in origin; but other factors also play a role in determining health. Women are less likely than men to say they are healthy. Women and men also differ in the types of ailments they report. Any strategy addressing clergy health will need to take these differences into account.

4. Age is a factor in physical and emotional health. Younger clergy are physically healthier than older clergy, but research shows the opposite to be true from emotional health. Younger clergy are more likely to experience problems with emotional health than older counterparts. Older persons entering the ministry as second careers are not at the same risk for emotional health problems as younger clergy entering the ministry.

5. The balance of church and home is the issue most addressed in the literature. The need to balance the demands of work with home life is the issue most commonly raised in the literature. How the boundary between home and congregational life is drawn is of vital importance to the health of individual clergy and to the health of clergy families, as well. This is an important issue with regards to clergy retention.

6. Stress and job satisfaction are largely a function of the nature of congregational life.

“Although stress and satisfaction were related significantly to working hours, salary and benefits, they were much more strongly related to characteristics of the congregation’s functioning, including its morale, the presence of conflict, lack of a shared understanding of the role of pastor and problems with other staff or lay leaders.” (Royle 2005, 24) Several lines of research, including Royle’s quoted above, suggest that the overall systemic problems clergy face have a greater impact on their overall health than specific incidents involving congregation members.

Recommendations

Given these conclusions, what can United Methodist’s do to improve clergy health? First, any recommendations or actions must:

- 1) Take into account the particularities of age and gender.
- 2) Give equal weight to medical issues. Because emotional issues have received more attention in past research, a greater emphasis on physical health issues is needed now.
- 3) Consider the interplay between congregational life and clergy health. Because this consideration involves not only the clergy themselves but the environment in which they work, it may be the most difficult to include in any plan.

Further Research

There is still much more to learn on issues of clergy health. This review points up several areas that warrant further review and research.

- 1) Issues surrounding itinerancy and clergy health require attention. In all likelihood there are both positive implications, such as sense of job security, and negative implications, such as feelings of helplessness.
- 2) Issues related to access to health care deserve consideration. Most, if not all, United Methodist clergy have health insurance; but clergy have varying access to health care because of their geographic location or difficulties in finding health care providers that accept their insurance.
- 3) Collecting data on clergy health in The United Methodist Church on a regular and ongoing basis would allow for comparison, the monitoring of progress, and the early detection of trends that will allow the church to be proactive rather than reactive.
- 4) Increasing the research and collection of information around medical issues and the clergy to learn what strengths and weaknesses are present.

Lewis, Christopher A., Douglas W. Turton, Leslie J. Francis. 2007. Clergy work-related psychological health, stress, and burnout: An introduction to this special issue. *Mental Health, Religion and Culture*. 10, no.1 (January): 1-8.

Clergy Health A Review of Literature

The health of any organization's workforce is important to its overall success and productivity. The church gets no religious exemption from this requirement. Just as many companies have begun to look more seriously at the health and well-being of their employees, many denominations also have begun to look at the health of the clergy that serve in their churches. Collecting and analyzing workforce health data has allowed many corporations to help their workers lead healthier and more productive lives, which can improve a company's overall success. Denominations, too, are beginning to see how focusing on clergy health might enhance their fruitfulness in spreading the good news of Jesus Christ.

Within the universe of general health literature and research related to clergy, there is a much smaller body of literature that specifically considers the health of clergy. The purpose of this literature review is to examine that body of literature.

Three criteria were used to determine which works would be included in the review:

- 1) Did the work involve primary research with clergy? Every effort was made to locate studies that asked clergy to provide specific facts, data, views, and opinions on their health and well-being.
- 2) Was the primary focus the emotional or physical health of clergy?
- 3) Is the work current, or at least the most recent available research on the subject?

Although the review focuses on clergy health research, other material (such as health guides, self-help materials, and other writings) were used to define the scope of the review.

This review is not an exhaustive catalog of all recent studies of clergy health, but it is a broad and comprehensive review of the studies relevant to United Methodist clergy. The report

is divided into five sections, addressing definitions of health, theology of health, emotional health, physical health, and conclusions.

What is Clergy Health? - Definitions

To assess clergy health, one must first define clergy health. A review of the literature reveals a notable expansion of this concept over time – from an emphasis on physical health alone to a more holistic concept of wellness that includes healthy attitudes, habits, and relationships.

The earliest studies of clergy health focused on *longevity*. Studies of mortality, some dating back to the 1700s, noted that clergy tended to live longer than other professionals. This was often attributed to certain lifestyle choices, such as the avoidance of alcohol and tobacco. (Flannelly 2002, 65)

More recent studies have defined clergy health more broadly, as *well-being*. Reports prepared for the Episcopal Church and the Evangelical Lutheran Church in America (ELCA) cite the World Health Organization's (WHO) definition of health. WHO defines health as the ability of an individual to achieve his or her potential and to respond positively to the challenges of the environment.

The *Episcopal Clergy Wellness* report prepared in 2006 provides more nuanced definitions of health, well-being, and wellness.

Traditionally, "health" has been defined mostly in terms of medically established, satisfactory levels of physiological or psychological indicators (i.e., physical, mental and emotional health). "Well-being" is defined as a holistic term that goes beyond specific symptom indicators of physical, mental, and emotional health to consider the attitudinal states that shape the whole person – the individuals overall positive frame and outlook toward life, work, and prospects for happiness. "Wellness" – the broadest possible term that encompasses both health and well-being is that of wellness – an overarching or umbrella term that

takes into account the past, current and desired future status of the individual's health and well-being. (Credo Institute 2006, 21-22)

The Episcopal report and the ELCA's *Ministerial Health and Wellness* report attempt to relate secular definitions and models of health to the lives of clergypersons. The Episcopal report builds a model of clergy wellness that includes the concept of boundaries, demographic status, and occupational factors, as well as attitudes, behaviors, and organizational consequences. This model is based on secular studies conducted over the last 25 years by Karen Danna and Ricky W. Griffin of Texas A&M University. (Credo 2006, 20) The ELCA study took a different approach. Analyzing interviews with bishops conducted periodically by their Board of Pensions, the study developed a composite picture of clergy health:

The responses relate to all aspects of health and include good self-care, routine exercise, and good sleeping habits. Healthy pastors are described as having good relationships, including good marriages, supportive spouses and family structures, and good relationships with their congregations. They have a passion and vision for ministry, the ability to handle stress and seek balance in life, the recognition of boundaries both personal and professional, and the ability to manage and be accountable. They are alive spiritually with a significant prayer and devotional life and a Lutheran sense of being called. Healthy pastors have mentors and collegial relationships, pursue lifelong learning, and feel valued. They take vacations and sabbaticals. Finally, they have a good sense of humor. (Halass 2002,10)

This broader notion of clergy health is evident in much of the more recent literature including studies of physical health and life practices among Episcopal, ELCA, and Presbyterian clergy and studies of stress and mental health conducted among United Church of Christ (UCC), United Methodist, and Seventh-Day Adventist pastors.

One additional factor not covered in these definitions is access to health care resources. Clergy health literature notes the importance of health care access, including access to mental health care. The recommendations of denominational reports consistently mention this factor.

A comprehensive definition of clergy health and well-being supported by the literature includes, therefore, not only traditional medical indices of physical and mental health but also self-care practices and access to health care resources; supportive personal and professional relationships; balance and coping skills; positive attitudes and outlook; and a passion for ministry grounded in a robust spiritual life.

What is Clergy Health? – Theology

Clergy health literature places the issue in a larger theological framework that views health from the perspective of a theology of ministry and God's ultimate intentions for creation.

The ELCA report holds up Genesis 1–2 as the ultimate picture of health for humanity.

The pictures of Adam and Eve at rest in the garden and then actively involved in God's whole creation set the context for all biblical discussions of health and healing. Hold on to the fleeting image of the seventh day because in it we see God's intent humans and all other creatures at ease in harmony, resting in the presence of the Creator. Our first picture of health, then is an ecological one, a picture of people in perfect relation to God, neighbor, self, and cosmos. (Halaas 2002, 9-10)

The *Episcopal Clergy Wellness* report prepared by the Credo Institute takes the ministry of Jesus as the touchstone for theological discussions of health. The report marshals a wide variety of theological material, from the stories of healings to the relationship of the Holy Trinity.

The concept of wellness lies very close to the heart of the gospel. Jesus said he came so that we might have abundant life. He tells his friends that they must be whole, wholesome, completed, just as God is: "Be perfect, just as your heavenly Father is perfect." [Matthew 5:48] The Greek word we translate as perfect is teleios, which means to be brought to completion, maturity, to wholeness. Perhaps the most significant sign of Jesus' identity and his inauguration of the Reign of God was his ministry of healing. (Credo Institute 2006, 6)

Jürgen Moltmann echoes this theme in his work *The Spirit of Life: A Universal Affirmation*. The healing of the sick, argues Moltmann, was a charge Jesus gave to the disciples and as such is a part of the apostolate. “The experiences of healing in physical and mental illness therefore also belong to the charismatic experience of life. In the context of faith, healings are signs of the new creation and the rebirth of life.” (Moltmann 1992, 189)

Turning to the biblical concept of the Sabbath, in the survey of Presbyterian clergy there are questions about clergy taking Sabbaths. There is no discussion of the theology of the Sabbath or the practice of taking Sabbath rests. But a guide on sabbatical planning notes that “the pursuit of renewal by clergy and leadership sets a good model for the congregation and its individual members by emphasizing the importance of incorporating Sabbath keeping, rest and renewal, in the rhythms of life. It also benefits the congregation to have renewed leadership.” (Bullock 2000, 8)

The Credo Institute’s report concludes its discussion of theology and clergy health with an affirmation that healthy clergy is important to the completion of God’s action in the Church.

Strong, loving, and wise leaders are necessary for the mission of the Church. The wisdom of the monastic tradition reminds us that a healthy community depends on a rich diversity of relationships and that those relationships must be freely disciplined. The Rule of St. Benedict insists that this is a matter of deep obedience to Christ, the transformation of the will and the heart in the love of God. The community is ordered not for its own sake, but so that the gifts of all may be identified, cherished, and put to good use. Ordained ministry, Holy Order exists in the Church to assure an environment in which diversity may flourish for the sake of the resiliency, the vitality of the whole body. (Credo Institute 2006, 7)

Emotional Health

Emotional health is an important component of overall health and well-being. “Clergy work-related poor psychological health, stress, and burnout pose an increasingly serious problem for the leaders of denominations throughout the world, as the particular circumstances related to

the spiritual and religious leadership in the community have a special unique dynamic.” (Lewis 2007, 2)

A considerable body of literature addresses the emotional health of clergy. There is, in fact, more data about their emotional health than their physical well-being. This literature review will consider some of the common recurring themes in the most recent works on emotional health.

Terminology becomes significant when examining the literature of clergy health. Terms such as *stress*, *burnout*, *exhaustion*, *demands*, *coping*, and *depression* are used frequently and often almost interchangeably. Stress, for example, is an important but difficult concept to define.

Although stress is a widely used concept, it is notoriously difficult to define and measure because, essentially, it is subjective and individual. Any definition of stress must include events that demand that an individual adapt to them, individual responses to those events, and appraisals of the events as stressful. (Cohen 1997, 3) Cohen and his colleagues define stress as “process in which environmental demands tax or exceed the adaptive capacity of an organism, resulting in psychological and biological changes that may place persons at risk for disease.” People say that situations are stressful, or they report that they feel stressed, but situations that are stressful for one person may not be for another. The absence of stress is boredom, and a low level of stress may be enjoyable or challenging, which a high level of stress is not. But what is high differs by individual or by the situation within individuals. Chronic low levels of stress can be as debilitating as brief, stressful situations. In addition, stress may differ across different aspects of life, such as job-related, financial, or interpersonal, and stress in one aspect can spill over into another, as when financial stress, caused by a poorly-paying job, causes stress in a relationship with a spouse or partner. (Royle 2005, 24)

Thus, it is important to consider the context in which terms such as *stress* are used. For the purpose of this review, emotional health is taken to mean those conditions which are primarily psychological, whether the cause is internal or external to the clergy person.

Job satisfaction, stress, and pastoral demands. Research on job satisfaction in the United States holds some good news for clergy. Among all the professions surveyed, clergy were most likely to indicate they were very satisfied with their job – 87.3% of clergy compared to the national average of 47%. (Smith 2007, 1)

Given this high level of job satisfaction, it is perhaps noteworthy that clergy also report high levels of stress. Studies have shown that United Methodist clergy spend an average of 56.2 hours a week working and 12 evenings a month away from home. And Protestant clergy in general had the highest work-related stress. (Flannelly 2002, 58) There is much speculation in the literature attempting to explain the seeming paradox between high career satisfaction and high stress. Courtney Wilder, for example, posits that a sense of vocation might explain high stress and high satisfaction.

The very nature of a pastor’s everyday work results in some unique demands and expectations. The variety of a pastor’s tasks combined with the sense of urgency attached to the church’s mission can cause church leaders to “become the victim[s] of their own human frailty.” (Lewis 2007, 2) Benjamin Doolittle’s study of United Methodist clergy notes that “their jobs have varied demands, public speaking, personal counseling, teamwork facilitation, and budget administration, which may make for a stressful environment.” (Doolittle 2007, 35)

Interestingly, a study by Edward Kemery (2006) found that the varied nature of a pastor’s job may actually lessen stress. Kemery used the concepts of *role ambiguity* and *role conflict* to look at the ways pastors go about their work. Kemery defined *role ambiguity* as “a lack of daily structure, uncertainty about authority, unclear planned goals and objectives, and uncertainty about other expectations.” (Kemery 2006, 566) On the other hand, *role conflict* is the occurrence of two or more role expectations, so that doing one would make doing the other difficult or

impossible. Kemery found that “clergy satisfaction was found highest when *role ambiguity* was high and *role conflict* was low. Satisfaction was lowest when *role ambiguity* and *role conflict* were both high.” (Kemery 2006, 566) He notes that from a remedial perspective churches should try to minimize *role conflict*.

Other research by Royle (2005) and Doolittle (2007) touch briefly on this topic as well. Royle observes of UCC pastors: “Although stress and satisfaction were related significantly to working hours, salary and benefits, they were much more strongly related to characteristics of the congregation’s functioning, including its morale, the presence of conflict, lack of a shared understanding of the role of pastor and problems with other staff or lay leaders.” (Royle 2005, 24) In general, the literature shows it is the ongoing, larger patterns of congregational life that most dramatically affect the overall emotional health of the pastor, not the myriad of smaller incidents.

Gender also affects how pastors balance the demands of their roles. “Female ministers demonstrated a better sense of understanding what they need to do in their vocation and how to accomplish it than their male colleagues. Clergywomen also appeared to have fewer problems in setting limits with others, reported greater cognitive coping skills, and suffered less stress from feelings of being trapped in conflicts than did the males.” (Weaver 2002, 395)

Clergy stress can have serious consequences. A 1993 study of Southern Baptist ministers showed a strong association between high levels of stress and incidents of sexual misconduct with adult members of the congregation. (Weaver 2002, 400) But the most common consequence of stress seems to be pastors leaving congregational ministry. Studies by Hoge (2005), Royle (2005), and Doolittle (2007) reveal that burnout and stress are higher among those who leave the pastorate.

Demands of family and self. All working people must balance the responsibilities of their work and family life. But this tension seems particularly pronounced for clergy. There is more literature addressing this aspect of emotional health than the demands that arise from congregational concerns. Almost inevitably, problems in the congregation spill over into a clergyperson's home life. A study of UCC clergy found that pastors in stressful work situations were significantly more likely to report problems at home. (Royle 2005, 20)

Some family stress therapists have noted that many clergy have an ambiguous boundary between work and home life. A study of Episcopal clergy looked specifically at the living situations of clergy and their families. "Episcopal clergy who do not live in a church-owned rectory (i.e. they own or rent their residence) have higher levels of vocational satisfaction and work-life balance ... Those who own or rent their housing also have a lower level of organizational identification." (Credo 2006, 31)

Gender also plays a role in how family demands impact clergy. Studies conducted by This (2006), Credo (2005), and Royle (2005) all note that marriage is a positive contributor for male clergy, but a negative contributor for female clergy. However, none of these studies addresses the reason for this disparity.

Overall women reported having lower mental health than men, but the degree of the difference was generally not significant. In a study of 190 United Methodist clergypersons "the themes that emerged clustered around the balance of work and family, having more free time, cultivating more support, and having an opportunity to develop their spiritual lives more fully." (Frame 2004, 377)

Marriage also plays a role in the emotional dynamic. A study of Seventh Day Adventist clergy was one of the few that included both clergy and their spouses. It found that:

Pastors experience higher levels of demands than their spouses, but generally have higher levels of support as well. The single exception is that wives report a significantly higher number of supportive family relationships. Pastors also appear to have broader networks of social support than their wives, with the exception of family support. This may mean that wives perceive the members of their nuclear families as being more supportive than the pastors do. Satisfaction with social support is the variable most highly correlated with both well-being and ministry attitude, and here that is no difference between spouses. (Lee 2007, 766-768)

A UCC study (Lee 2007, 762) found that a spouse's feeling factored into a pastor's decision to leave the ministry. One-third of 131 UCC clergy who left the ministry noted that the "wife or family" was unhappy.

Another area of interest for United Methodist clergy is how relocation to a new appointment impacts emotional health and family relationships. In a study of United Methodist clergy and spouses in the Florida Annual Conference researchers found differences in how clergy and their spouses responded to the move.

Differences in well-being among clergy and spouses were significant, suggesting that clergy spouses experience more relocation distress than their mates. This finding is consistent with nearly all other research results which focused on relocating spouses. In these studies, lower well-being was manifest in depression, sadness, loneliness and alienation from the community. Indeed in this study, clergy spouses wrote comments indicating grief and loneliness as consequences of relocation nearly three times as often as did their mates. Lower well-being in clergy spouses also may be explained by the fact that clergy have a built-in support system through denominational structures. (Frame 1998, 424)

Age and entry into ministry. Several recent studies have examined the impact that age and age of entry into ministry have on the emotional health of clergy. In the general population, mental health generally improves with age. This has been demonstrated in numerous studies of clergy, as well. (Credo 2006, Halass 2002, Royle 2005)

Several studies have noted younger pastors tend to have more stress and are at greater risk for burnout. For example, a study of theological graduates in Australia found that the first

12 months of ministry were generally characterized by moderate levels of stress, with relational and ministry issues contributing most to stress. (Miner 2007, 14) “Conflicts were highly stressful, suggesting that theological students might benefit from more training in conflict resolution.” (Miner 2007, 14) This study, as well as other research, shows that problem-solving strategies are not as effective at minimizing stress as emotional coping strategies. “Holding to one’s childhood faith without questioning” is another factor that can cause burnout early in ministry. (Miner 2007, 15) In Royle’s study of UCC clergy, those in their 30’s worked the most hours and spent the least time with family or in recreation. (Royle 2005, 15)

Study of Anglican clergy in England and Wales revealed that the propensity for burnout was greatest among the youngest clergy. The study concluded that in their first year of ministry older people are less prone to burnout than younger people. (Randall 2007, 43) The study’s author poses an important question:

How do the churches deal with this? By not choosing younger candidates? ... Other professions, such as teaching, where this is the same burnout likelihood for young entrants and where this a significant drop-out rate, have not chosen to dissuade young entrants from applying. Instead, individual centered solutions and organization centered solutions have been put in place. A wide variety of intervention strategies have been tried in people focused professions, including stress training, time management, assertiveness training, training in interpersonal and social skills, relaxation, and team-building. It is the organization’s responsibility to establish work conditions that minimize burnout. Advice for organizations usually focuses on areas such as a strong supportive leadership, realistic expectations of workload, shared values, mutual support groups, high levels of collegiality, and high levels of influence on decision-making. (Randall 2007, 44)

Doolittle’s study of United Methodist clergy notes an important distinction. While younger clergy have higher rates of burnout, “age is a non-significant predictor of the burnout syndrome.” So while there is greater danger of burnout at a younger age, age alone does not significantly indicate who will burnout. Doolittle concludes:

These data suggest that there may be a certain personality type that would succeed in the particular demands of parish life: one with a strong spiritual life, with an ability to reflect, who employs healthy, adaptive emotional coping strategies. Fostering healthy, adaptive coping strategies and facilitating the spiritual lives of clergy are important for the health of the profession and, by extension the health of the wider church. In particular, nurturing healthy emotional coping strategies should be specifically focused on younger clergy, who are at higher risk of burnout and in the process of refining their pastoral practices. (Doolittle 2007, 37)

Physical Health – Trends

Detailed studies focusing on the physical health of clergy are a relatively recent phenomenon. One exception was Haitung King’s 1969 review of demographic literature related to clergy health. King noted that for 150 years almost every study comparing clergy and other professionals found that clergy lived the longest. But by the middle of twentieth century clergy were no longer the longest-lived professionals; their longevity had slipped below that of school teachers. (King 1969)

Mirroring the heightened concern for health in contemporary society, interest in the state of clergy health has increased in recent years. Several major U.S. denominations -- the Presbyterian Church (USA), the Evangelical Lutheran Church of America, the Episcopal Church, and The United Methodist Church -- have begun to look at the issue of clergy health, collecting data and developing strategies to address emerging issues.

Given the variety of data it is helpful to consider the physical health of clergy in terms of lifestyle and medical risks and consider the variables of age, gender, racial/ethnic background, and congregational size. The categories of lifestyle and medical risks come from the Mayo Clinic Health Risk Assessment. The Mayo Clinic defines “lifestyle risk factors” as behaviors related to alcohol use, emotional health, exercise, nutrition, safety, and tobacco use. “Medical risk factors” include blood pressure, blood sugar, cholesterol, triglycerides, and weight. (Credo

Institute 2006, 24-5) The Mayo Clinic notes: “Research shows that a relatively small number of health risk factors contribute to the majority of the causes of death among adults. This principal – that 20 percent of the health risk factors affect 80 percent of the causes of premature death – was used in selecting the 11 risk factors.” (Mayo Foundation, 2008)

Lifestyle Risks

Clergy tend to do better than the population as a whole in the lifestyle risk areas, except for emotional health, which was covered in an earlier section of this review.

Alcohol use. Studies of Episcopal and Lutheran clergy reveal a level of problem drinking higher than that of other professionals. The Credo Institute’s report on Episcopal clergy noted that 11.80% reported some problems with alcohol compared to 8.10% in comparable professions. In the ELCA study, a total of 10.4% of the clergy studied indicated drinking problems – 4.4% reported binge drinking and 6% said they consumed 10 or more drinks a week.

Exercise. Lack of exercise continues to be an issue for clergy, although many of the denominational studies suggest that clergy compare favorably to the US population as a whole by some measures of their level of exercise. Overall, 40% of Americans report that they do not exercise, compared to 22% of Presbyterian clergy and 22% clergy studied by the ELCA. However only 15% of ELCA clergy exercise 4 or more times a week, compared to 27% of the U.S. population overall. The Church Benefits study found 23.64% of clergy exercise 3 times a week across the studied denominations and 21.63% for United Methodist clergy. The study of Episcopal clergy found that they were 4% more likely to exercise than peers in similar professions. The Presbyterian study asked a question not pursued in other studies about gym/health club memberships. It found that 68% of Presbyterian clergy do not belong to a gym or health club.

Nutrition. A steady diet of church dinners and potlucks as well as time constraints and other factors contribute to poor dietary habits for many clergy. The study of Episcopal clergy reported that 71% of clergy cite nutrition as a risk factor. The ELCA study considered the intake of fat servings and fruits and vegetables. It found that 22 % ELCA clergy ate 5 servings of fruits and vegetables a day, in line with 22.7% of the U.S. population who report doing the same.

Safety. This category relates to those preventative measures, such as seat belt use, that can enhance an individual's safety and wellbeing. For Episcopal clergy this was the third highest life style risk, behind nutrition and stress. The good news in the Episcopal and ELCA studies is that clergy do better than the population as a whole. For example 75% of ELCA clergy always wore a seatbelt, while 68% of general population does.

Tobacco use. This is one area where clergy excel in denominational studies. In the United States today, 22% of people are smokers. Among clergy the difference is striking, 7.9% for Episcopalians and 6% for ELCA.

Medical Risks

The picture for clergy on medical risks is more mixed than on lifestyle risks. Medical risks include blood pressure, blood sugar, cholesterol, triglycerides, and weight.

Blood pressure. The Centers for Disease Control estimates that one-third of Americans have high blood pressure, but many do not know it because they experience no symptoms. In the study of ELCA clergy, 22% reported high blood pressure, 50% reported a family history of high blood pressure, and an encouraging 91% had their blood pressure checked in the last year. The study of Episcopal clergy found 63% were at risk for high blood pressure, ranking third behind stress and weight as risk factors. The Church Benefits survey looking at pharmacy claims

showed 15.78% of claims from United Methodist were for antihypertensive drugs, slightly lower than all denominations in the study which had 17.83% of claims for such drugs.

Blood sugar. Elevated levels of blood sugar afflict 6.3% of the U.S. population and are one of the ten leading causes of death. The ELCA and Episcopal studies found differing situations with regard to blood sugar problems among their clergy. The ELCA clergy reported an incidence of 6%, which is in line with national estimates, but the Episcopal study found 18.6% at risk for blood sugar, compared to 7.8% in benchmark professions. The difference in percentages may be attributable to the fact that the ELCA study reported diagnosed blood sugar problems while the Episcopal study reported those who were at risk. There is reason to be attentive to the issue given the 11% difference the Mayo Clinic Health Risk Assessment found between Episcopal clergy and benchmark professions. The Church Benefits survey found that United Methodist and Other Denominations pharmacy claims for Endocrine/Diabetes drugs were similar at 12.09% and 13.47% respectively.

Cholesterol. High cholesterol levels are a problem for about 17% of American adults. For Episcopal clergy, however, the risk of high cholesterol levels was 31.6% -- significantly more than the 11.6% in benchmark professions. In the Church Benefits survey 9.31% of United Methodist pharmacy claims were for drugs related to cholesterol, with 8.66% in the other denominations studied. While the ELCA study did not ask about cholesterol levels, some other factors may signal the potential presence of a problem. For example, 53% of the clergy surveyed say they want to cut back on fatty food and 34% were overweight.

Triglycerides. Triglycerides are a fatty substance in the blood. At high levels, they can contribute to heart disease. Only the Episcopal study considered triglycerides. It found that

7.8% of Episcopal clergy had risk of high triglyceride levels, just below the benchmark of 8.1% among similar professionals. This was the lowest ranking risk factor for Episcopal clergy.

Obesity. Obesity is a serious health problem for Americans. Thirty-three percent of American men and 35% of American women are considered obese (having a body mass index of 30 or greater). Clergy are not immune to the problem – although existing evidence suggests that clergy may be slightly less prone to obesity and weight problems than the overall population.

	Obese BMI of 30 or more		Overweight BMI of 25 or more	
	Men	Women	Men	Women
American Population	33%	35%	67%	62%
Presbyterian Clergy	23%	28%	34%	35%

Among Episcopalians 64% had risks from weight and in the three denominational studies it was found that between 64% and 68% of clergy had an issue with weight.

Physical Health and Contributing Characteristics

A number of contributing characteristics influence the state of clergy health. What do these various characteristics say about the physical health of clergy?

Age. Age is an important factor in health. Studies reveal that with advancing age physical health declines while mental health increases. This is true for clergy and the general population. Neither the Episcopal study nor the ELCA study looked at specific instances of health by age, other than stress and perceptions of health. However, given the profile of clergy in these denominations, both studies included a large number of older adults. The average age of clergy in the ELCA report was 51.57 years for men and 46.53 years for women. In the Episcopal

study 81% of respondents were 50 or older. In this study, Episcopal clergy over 40 reported higher self perceptions of health than those under 40. But those under 40 reported fewer risk factors.

Gender. Gender is another important variable to consider in assessing health. In the Presbyterian study, male clergy were more likely to describe their health as excellent. Forty six percent of male Presbyterian clergy reported excellent health compared to 40% of their female colleagues. Results were similar among ELCA clergy with 42% of male clergy describing their health as excellent compared to 33% of women. The Church Benefits Association survey of clergy (Meador 2007) notes that female clergy report lower levels of physical health than male counterparts.

The ELCA study offers a more detailed look at gender differences:

Health Issue	Men	Women
Health Excellent	42%	33%
Health Good	51%	57%
High Blood Pressure	23%	18%
Heart Attacks	2.3%	1%
Arthritis	12%	21%
Depression	16%	24%
Chronic Back Pain	9%	14%
Cancer	6%	6%

This study also found that women smoke and drink less than men and they are more likely to have had a physical in the last year and to use seatbelts. But women are less likely than men to have a flu shot, have checked cholesterol in the last year, and to exercise. Among Presbyterian clergy, 76% of women said they had made changes in the last year to improve their health, only 59% of the men had made changes.

Race and Ethnicity. With regards to race and ethnicity, the ELCA study found that clergy of color were less likely to describe their health as excellent. Thirty-four percent of clergy

of color reported excellent health compared to 40% overall. Their profile was similar to other clergy in the survey in terms of age and obesity. But there were marked differences in certain areas of health risk. Clergy of color were 5% more likely to have high blood pressure and almost twice as likely to have blood sugar problems. However, their cancer rate was half that of the overall group -- 3% compared to 6% for all respondents. A higher percentage of clergy of color reported no exercise -- 27% compared to 22% overall. They were similar to the overall ELCA clergy population in terms of smoking, drinking, checking blood pressure, and seatbelt use. They were more likely to check cholesterol, and less likely to get a flu shot.

Congregational size. Deborah Bruce of the Research Service of the Presbyterian Church (USA) (Bruce 2005) looked at the effect the size of congregation had on clergy experience. Bruce noted that there are no significant differences based on church size. There are, however, some interesting trends that bear mention. While clergy serving churches with less than 100 persons have a body mass index in line with those in larger churches, the rate of obesity in small church pastors is the highest of any group at 31%. This rate is 5% greater than mid-size pastors, 9% greater than large church pastors, and 15% greater than mega church pastors. Clergy serving small congregations also have lower levels of self-perceived health. Seventy-three percent of small church pastors reported good or excellent health compared to 78% to 84% of pastors of larger churches.

Craig This's (This 2006) analysis of clergy data from the Church Benefits Association finds that United Methodist clergy in rural settings have decreased physical health. While his findings do not refer explicitly to congregational size, one could infer that rural congregations are likely to be smaller.

Conclusions and Recommendations

There are some patterns and themes that emerge from these statistics, findings, and studies. Six particular conclusions are worthy of lifting up for consideration.

1. Clergy health is a mixed picture. While there are some problem areas that clergy share with the general population (e.g. weight) and areas that need more research (e.g. medical issues), these factors should not obscure some of the hopeful aspects of the findings. In general, clergy report better health than the population as a whole and exercise more often. The available research shows that clergy smoke less, drink less, exercise more often, and take more safety precautions than the population as a whole. These habits provide The United Methodist Church with a solid foundation for efforts to improve clergy health.

2. Medical risks are present for clergy and need further study. While clergy do experience emotional health problems, evidence suggests that they are more prone to medical issues like blood sugar, blood pressure, cholesterol, and the like. While clergy may be doing better than the general population in some of these measures, there is less clear of a distinction here than there is on matters of lifestyle risk, such as alcohol and tobacco use. There is a lack of direct evidence on many of these concerns. Much more work is necessary to assess the physical health of clergy and to address the issues that emerge.

3. Clergymen and clergywomen differ in their level of health and their perceptions of health. This is shown to be true study after study. Some of the difference is biological in origin; but other factors also play a role in determining health. Women are less likely than men to say they are healthy. Women and men also differ in the types of ailments they report. Any strategy addressing clergy health will need to take these differences into account.

4. Age is a factor in physical and emotional health. Younger clergy are physically healthier than older clergy, but research shows the opposite to be true from emotional health. Younger clergy are more likely to experience problems with emotional health than older counterparts. Older persons entering the ministry as second careers are not at the same risk for emotional health problems as younger clergy entering the ministry.

5. The balance of church and home is the issue most addressed in the literature. The need to balance the demands of work with home life is the issue most commonly raised in the literature. How the boundary between home and congregational life is drawn is of vital importance to the health of individual clergy and to the health of clergy families, as well. This is an important issue with regards to clergy retention.

6. Stress and job satisfaction are largely a function of the nature of congregational life. “Although stress and satisfaction were related significantly to working hours, salary and benefits, they were much more strongly related to characteristics of the congregation’s functioning, including its morale, the presence of conflict, lack of a shared understanding of the role of pastor and problems with other staff or lay leaders.” (Royle 2005, 24) Several lines of research, including Royle’s quoted above, suggest that the overall systemic problems clergy face have a greater impact on their overall health than specific incidents involving congregation members.

Given these conclusions, what can United Methodist’s do to improve clergy health?

First, any recommendations or actions must:

- 1) Take into account the particularities of age and gender.
- 2) Give equal weight to medical issues. Because emotional issues have received more attention in past research, a greater emphasis on physical health issues is needed now.

- 3) Consider the interplay between congregational life and clergy health. Because this consideration involves not only the clergy themselves but the environment in which they work, it may be the most difficult to include in any plan.

There is still much more to learn on issues of clergy health. This review points up several areas that warrant further review and research.

- 1) Issues surrounding itinerancy and clergy health require attention. In all likelihood there are both positive implications, such as sense of job security, and negative implications, such as feelings of helplessness.
- 2) Issues related to access to health care deserve consideration. Most, if not all, United Methodist clergy have health insurance; but clergy have varying access to health care because of their geographic location or difficulties in finding health care providers that accept their insurance.
- 3) Collecting data on clergy health in The United Methodist Church on a regular and ongoing basis would allow for comparison, the monitoring of progress, and the early detection of trends that will allow the church to be proactive rather than reactive.
- 4) Increasing the research and collection of information around medical issues and the clergy to learn what strengths and weaknesses are present.

In conclusion, the state of clergy health is mixed. There is reason to celebrate and reason for concern. The church must be concerned with clergy health because clergy are children of God. Indeed, they are children of God set aside for a special purpose. As John Wesley wrote to a friend, "I am glad that it has pleased God to restore your health, and that you have been employing it to the best of purposes. It is worth living for this, (and scarcely for anything else,) to testify the Gospel of the grace of God." (Telford 1960, 377)

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