

A Prospective Study of Clergy Spiritual Well-Being, Depressive Symptoms, and Occupational Distress

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Abstract

Work, when stressful, can be dispiriting. There are bi-

directional and longitudinal links between occupational stress and depressive symptoms. Also, higher levels of religious participation are associated with lower levels of depressive symptoms and work distress. Some have argued that religious participation is a proxy for social support, rather than an independent variable. In order to study the independent association of religious participation with depressive symptoms and occupational distress, this longitudinal study of 895 United Methodist clergy measured the prospective relationships of spiritual well-being, depressive symptoms, and occupational distress, while controlling for a measure of social support. As expected, spiritual well-being, depressive symptoms and occupational distress were all significantly correlated at Time 1. Residualized change linear regression models assessed their prospective effects between Time 1 and Time 2 (one year later). Higher levels of spiritual well-being were protective against increased depressive symptoms, even when controlling for perceived emotional support. In addition, lower levels of depressive symptoms were protective against increased occupational distress. Surprisingly, occupational distress did not predict depressive symptoms. Neither occupational distress nor depressive symptoms predicted spiritual well-being. The findings indicate a longitudinal and directional pattern, with lower spiritual well-being predicting depressive symptoms, which in turn predicted occupational distress. These findings suggest future intervention research for clergy, with a focus on spiritual well-being, and an overall goal of reducing depression and improving occupational function. More broadly, the results support an effect of spiritual well-being independent of social support.

KEYWORDS

Clergy; spirituality; religiosity; depression; occupational stress; social support; perceived emotional support

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Introduction

Work, when stressful, can be dispiriting. Studies have consistently found links between occupational stress and depressive symptoms [1]. Longitudinally, depressive symptoms have predicted later occupational distress, including reduced engagement and increased burnout [2], and vice versa, negative occupational attributes have predicted later depressive symptoms [3, 4, 5]. These occupational stressors can, in turn, be buffered by social support [6].

One area with substantial research is the role of religion and spirituality in relation to depression and occupational stress. A meta-analysis of 147 studies (N = 98,975) found the “religiousness–depression relationship as a reliable phenomenon” [7], with greater religiosity associated with less depression. Longitudinal studies also find this relationship. For example, a prospective study of 7,732 older adults across two years found that individuals not depressed at baseline remained nondepressed if they reported frequently attending religious services, and those depressed at baseline were less likely to be depressed 2 years later if they reported more frequently engaging in private prayer [8]. With the overall relationship established, researchers have turned to understanding what aspects of religiosity and spirituality predict better – or worse – depression outcomes. In one example, more negative religious coping which includes feelings of spiritual discontent and abandonment [9], was found – in a prospective study of undergraduates with high religious commitment – to relate to significantly higher levels of depressive symptoms as stress increased [10].

Data have also linked spiritual well-being to occupational distress in clergy. A prospective, three-wave, eighteen month study of 399 clergy found that spiritual resources at Time 1 had a positive effect on work engagement (e.g. vigor, dedication, absorption) nine months later at Time 2, which in turn had a negative effect on turnover intention (e.g., answering no to “I will probably look for a new job in the near future”) another nine months later at Time 3 [11].

There is an active argument among those who study health and psychology as to what unique attributes, if any, there are to religious variables on well-being [12]. In particular, do religious beliefs and spirituality affect health independently of the effects of emotional supports and community connections? Some challenge whether religious involvement is an

independent variable, and instead reason that, “there is nothing special about religiosity’s effects on mental health — it reduces to the well-known effects of social support” [13]. In contrast, other researchers point to the ubiquity of religion across humanity, as well as the tenacity of religious involvement in persons’ lives across their lifespans. Kenneth Pargament [14] has argued that one must study religion to understand human health because, “the ties between spiritual pathways, health, and well-being may be irreducibly linked to their basic sacred character.” Recent research reviews have identified unique contributions of religious practice to longitudinal health [15]. To access these effects, researchers would be well-served to employ measures specific to the religious traditions and beliefs of the persons being studied [16, 17, 18].

We sought to examine the relationships between spiritual well-being, depressive symptoms, and occupational distress, taking into account perceived emotional support, using longitudinal data from a large sample of United Methodist Church (UMC) clergy. For this particular set of research questions, studying UMC clergy offers several advantages, including having an above-average depression prevalence [19] and shared religious beliefs. Examining the longitudinal relationships between these variables will add to the literature in two ways: 1) assess if there is a directionality to the relationships and 2) determine if there is a unique contribution of spiritual well-being when controlling for emotional support.

We had several hypotheses about the relationships between study variables and their timing.

1. Depressive Symptoms.

In controlled analyses, higher levels of occupational distress at Time 1 will predict increased levels of depressive symptoms at Time 2, one year later; higher levels of spiritual well-being at Time 1 will predict decreased levels of depressive symptoms at Time 2.

2. Occupational Distress.

In controlled analyses, higher levels of depressive symptoms at Time 1 will predict increased levels of occupational distress at Time 2; higher levels of spiritual well-being at Time 1 will predict decreased levels of occupational distress at Time 2.

3. Spiritual Well-Being.

In controlled analyses, higher levels of depressive symptoms and occupational distress at Time 1, will each predict decreased levels of spiritual well-being at Time 2.

Methods

Study Sample

The sample consisted of 895 survey participants in the Spirited Life study [20]. Spirited Life was a randomized trial designed to test the effects of lifestyle interventions primarily on metabolic syndrome, and secondarily on depressive symptoms and stress, in United Methodist clergy in North Carolina. The social science research firm Westat was responsible for the survey data collection, which was online. Our sample for these analyses included clergy who participated in both the 2010 and 2011 Spirited Life surveys and were assigned to a congregation either part-time or full-time at the time of both assessments.

In the study design, consenting clergy who provided survey and physical health data in November-December 2010 (Time 1) were randomly assigned to one of three cohorts. The

cohorts began receiving interventions one year apart, such that the first cohort began the intervention in January 2011 and had received up to one year of intervention at the time of this study's second time point of interest, October-December 2011 (Time 2). The other cohorts began receiving the intervention later (January 2012 and January 2013, respectively). This study makes use of data from all three cohorts and statistically controls for cohort. The research protocols were initially approved and reviewed annually by the Duke University Arts and Sciences Institutional Review Board and the Westat Institutional Review Board. All participants gave free and informed consent.

Measures

Spiritual well-being. was measured using the Clergy Spiritual Well-Being (SWB) scale developed in collaboration with Methodist ministers [21]. It includes two components: 1) experiencing the "Presence and Power of God" in the everyday (SWB-Everyday) and 2) experiencing the "Presence and Power of God" in ministry (SWB-Ministry). Each component had six items. For each item, the possible range of scores was 0 to 4 with higher scores indicating higher spiritual well-being, for a possible scale range of 0 to 24 for each component.

The spiritual well-being in the everyday (SWB-Everyday) scale began by asking, "During the past six months, how often have you . . ." The participants then answered these personal items: "Experienced the presence and power of God in the ordinary?; observed the presence and power of God in your closest relationships?; consciously practiced discerning the presence and power of God?; felt God's grace and God's love for you as you are, apart from any accomplishments or good works?; felt that events were unfolding according to God's intent?; and felt that you have a vital relationship with God?"

The spiritual well-being in ministry (SWB-Ministry) scale began by asking, "During the past six months, how often have you felt the presence and power of God . . ." The participants then answered these vocational items: "In planning and leading worship?; when conducting pastoral visitations?; when participating in church-related events (e.g. Bible Study, fellowship time, etc.)?; when sharing in crisis intervention and counseling?; when sharing in the sacraments?; and in the midst of serious conflict?"

SWB-Everyday and SWB-Ministry were used as continuous variables. For regression analyses where spiritual well-being was used to predict depressive symptoms and occupational distress, spiritual well-being was centered at the mean. The two components of spiritual well-being were strongly correlated as described below and therefore were assessed in separate models.

Depressive symptoms. Measured using the self-report nine-item Patient Health Questionnaire (PHQ-9), which asks about the frequency of specific depressive symptoms experienced within the past two weeks [22, 23]. For each item of the PHQ-9, the possible range of scores was 0 to 3, with higher scores indicating more depressive symptoms, for a possible scale range of 0 to 27. The depressive symptoms score was used in these analyses as a continuous variable. For the regression analyses where depression score at Time 1 was a predictor of occupational distress and spiritual well-being, the depressive symptoms score was centered at the mean.

Occupational distress. Measured using the five-item Clergy Occupational Distress Index (CODI) [24], which assesses congregational demands. Two examples are: "How often during the past year have you experienced stress as a result of dealing with congregation members

who are critical of you?; How often during the past year have you felt lonely and isolated in your work?” For these analyses, responses were reverse coded on scales of 0-3 for each item, resulting in a scale range of 0-15 with higher numbers indicating more distress. The occupational distress score was used as a continuous variable. For regression analyses where occupational distress at Time 1 was used to predict depressive symptoms and spiritual well-being, the occupational distress score was centered at the mean.

Control variables. These are described below. They include demographic variables, appointment characteristics, other personal characteristics, intervention status, and perceived emotional support.

Demographic variables. Included age measured as a continuous variable, race category, sex, education (master’s degree or higher vs. fewer years of education), and marital status (married vs. not married) at baseline.

Appointment characteristics. Included full-time appointment vs. part-time appointment at baseline and whether or not the participant changed congregations between the Time 1 and Time 2 assessments (yes/no).

Other personal characteristics. Included self-rated physical health (fair/poor vs. excellent/very good/good) and self-rated financial stress (extremely, very, or moderately stressful vs. slightly or not at all stressful) at baseline.

Intervention group. Controlled in the analysis (yes/no received intervention in the first Spirited Life cohort).

Perceived emotional support. Measured using the eight emotional/informational support items from the Medical Outcomes Study – Social Support Survey (MOS-SSS) [25]. Each item was recoded with scores ranging from 0 (none of the time) to 4 (all of the time), for a scale range of 0 to 32. Perceived Emotional Support was used as a continuous variable and centered at the mean.

Statistical Analyses

We estimated three sets of residualized change linear regression models to assess the effects of depressive symptoms, occupational distress, and spiritual well-being (SWB) on each other.

In the first model, the independent variables were occupational distress and SWB at Time 1. The dependent variable was depressive symptoms score at Time 2. Control variables included depressive symptoms score at Time 1, whether or not the respondent participated in the 2010 intervention (i.e., intervention group), whether the participant changed church appointments between the two assessments, whether the participant worked full-time or part-time, age, race, sex, education, marital status, self-rated health, self-perceived financial stress, and perceived emotional support.

In the second model, depressive symptoms and SWB at Time 1 were used to predict occupational distress at Time 2, controlling for occupational distress score at Time 1 and the other control variables as listed above.

In the third model, depressive symptoms and occupational distress at Time 1 were used to predict SWB at Time 2, controlling for SWB at Time 1 and the other control variables as listed above.

All analyses were conducted using SAS Version 9.3 (SAS Institute, Cary, NC).

Results

Table 1 presents the characteristics of the sample at baseline (Time 1). On average, the sample was middle-aged, predominantly white, male, and married and had completed at least a master's degree. Most of the participants were working full-time and did not change congregations between the two assessments.

On average, the participants had only minimal depressive symptoms. Twelve percent had a score of 10 or higher on the depressive symptoms scale at baseline, indicating probable moderate or more severe depression. Longitudinally, 19% of the sample did not change depression scores between Time 1 and Time 2: 42% showed an increase while 39% saw a reduction in their depression symptoms. A total of 13% reduced their depression score by four or more points while 14% increased their score by four or more points (results not shown).

The mean occupational distress score was 6.6 ($sd=3.0$) in our sample of clergy. For comparison, the mean occupational distress score from a national sample of Protestant clergy from nine denominations was 10.98 ($sd=3.02$) (Frenk et al., 2013). We recoded our responses to reflect a range of 0 to 3 for each item rather than 1-4 as done in the Frenk et al. study [24]. A mean score of 10.98 on the original scale was equivalent to a score of 5.98 ($sd=3.02$) on our scale. A two-sample t-test confirmed that the mean occupational distress score found in our sample was significantly ($t = 4.34, p < 0.001$) higher than the mean occupational distress score reported by Frenk et al. [24].

Occupational distress scores did not change for 19% of the sample between Time 1 and Time 2: 56% saw a decrease in their score while 25% saw an increase. A total of 14% reduced their score by four or more points while 3% increased their score by four or more points (results not shown).

A total of 13% of the participants did not report a change in their Spiritual Well-Being in the Everyday: 43% reported a decrease in SWB-Everyday while 44% reported an increase between Time 1 and Time 2. A total of 15% decreased their SWB-Everyday by four or more points while 17% increased their SWB-Everyday by four or more points between Time 1 and Time 2. Similarly, 16% of the participants did not report a change in their Spiritual Well-Being in Ministry: 44% saw a decrease in SWB-Ministry between Time 1 and Time 2 while 40% reported an increase. A total of 16% decreased their SWB-Ministry by four or more points while 15% increased their SWB-Ministry score by four or more points. The observed changes also indicate that individuals' spiritual well-being is more transitory than dispositional, more state than trait (results not shown).

Table 2 shows that all correlations among the key variables at baseline were significant and in the expected direction. The correlation between SWB-Everyday and SWB-Ministry was especially large ($0.74, p < .0001$), as was the correlation between depressive symptoms and occupational distress ($0.51, p < .0001$). Because the Everyday and Ministry SWB scales were highly correlated, the regression models were estimated separately for each component.

Table 3 depicts the effects of variables at Time 1 on levels of depressive symptoms at Time 2. Occupational distress at Time 1 was not significantly associated with depressive symptoms at Time 2. SWB, both in the Everyday and in Ministry, were significant predictors of depressive symptoms one year later; higher levels of SWB-Everyday at Time 1 were associated with lower

levels of depressive symptoms at Time 2, as were higher levels of SWB-Ministry at Time 1 and depressive symptoms a year later.

Table 4 shows the effects of variables at Time 1, predicting levels of occupational distress at Time 2. Higher levels of depressive symptoms were associated with higher levels of occupational distress one year later. Levels of SWB were not significantly associated with occupational distress a year later.

As shown in Table 5, neither occupational distress nor depressive symptoms at Time 1 were significantly associated with Spiritual Well-Being at Time 2.

At Time 1, pastors who worked full-time, compared to pastors who worked less than full-time, had significantly higher levels of depressive symptoms ($p=0.0016$) and occupational distress ($p<0.0001$) and lower levels of SWB-Everyday ($p=0.0328$) and SWB-Ministry ($p=0.0158$). Receipt of the Spirited Life intervention (“Intervention Group”) between Time 1 and Time 2 was associated with lower levels of depressive symptoms at Time 2. Changing congregations had some positive consequences. As previously reported, changing appointments between Time 1 and Time 2 was associated with lower levels of depressive symptoms [26]. In addition, changing appointments was associated with higher levels of SWB in Ministry. Older age was associated with lower levels of occupational distress and higher levels of SWB-Everyday a year later. Both black participants and those of other races had higher levels of each SWB at Time 2 compared to whites. Being female was associated with higher levels of depressive symptoms at Time 2, and higher levels of education were associated with higher levels of occupational distress at Time 2. Higher levels of perceived emotional support at Time 1 were associated with lower levels of depressive symptoms, lower levels of occupational distress, and higher levels of SWB in both the Everyday and in Ministry at Time 2 (results not shown).

Discussion

Our primary findings describe directional, longitudinal effects of spiritual well-being on depressive symptoms, as well as depressive symptoms on occupational distress. As hypothesized, higher levels of spiritual well-being were protective against increased depressive symptoms a year later. This association was significant even when controlling for perceived emotional support. This finding supports an effect of spiritual well-being independent of social support, which has been an active area of inquest in the psychological study of religion [17, 13, 27, 15]. Also, as hypothesized, lower levels of depressive symptoms were protective against increased occupational distress a year later.

The data, however, did not support our hypotheses in other ways. Depressive symptoms were not predictive of spiritual well-being a year later, and occupational distress was not predictive of either depressive symptoms or spiritual well-being a year later. Also, spiritual well-being did not predict future levels of occupational distress. The findings do suggest a longitudinal and directional pattern, discussed below, that merits future study: spiritual well-being predicting depressive symptoms, which in turn predict occupational distress.

That higher levels of both measures of spiritual well-being were longitudinally predictive of lower levels of depressive symptoms is consistent with previous cross-sectional research on spirituality and depressive symptoms in clergy [28], and expands the empirical evidence of this

influence. The finding that this relationship between spiritual well-being and depressive symptoms was stronger for spiritual well-being in the everyday, than for spiritual well-being in ministry, is consistent with research that has identified personal relationships with trusted individuals as a protective factor for depressive symptoms [29, 30]. In the case of clergy, we speculate that one's personal relationship with God – as queried in the SWB-Everyday measure – may be protective, in ways similar to having a trusted friend. The current study – consistent with previous research on social support in clergy [31] – found that emotional support relates to fewer depressive symptoms. Also, spiritual well-being in the personal/everyday had a unique relationship to depressive symptoms above and beyond the perceived emotional support of friends.

The direction of influence in the data – wherein depressive symptoms predicted occupational distress – indicates that depressive symptoms may increase sensitivity to the pressures of the complex job of ministry, rather than that increased pressures in the ministry bring about depressive symptoms. Occupational distress in this study used items that examined the demands, criticism and stress perceived by clergy from their congregations.

That neither depressive symptoms nor occupational distress – both of which were significantly negatively correlated with spiritual well-being cross-sectionally at Time 1 – predicted spiritual well-being in Time 2, indicates that spiritual well-being may be an important attribute to measure and promote by intervention researchers, along with a focus on depression and occupational distress. There is a growing literature that shows positive emotions can co-exist with negative emotions [32, 33]. The current study adds to this literature in showing that not all variance in the positive outcome of spiritual well-being is explained by the negative emotion predictors of depressive symptoms and occupational distress.

We reported that levels of spiritual well-being of participants changed from Time 1 to Time 2, therefore, it seems possible that spiritual well-being is amenable to change, and such efforts to improve spiritual well-being among clergy may reduce future depressive symptoms, as suggested by this study's finding that higher levels of spiritual well-being at Time 1 predicted lower levels of depressive symptoms at Time 2. To promote spiritual well-being in clergy, clergy must first recognize that spiritual well-being is dynamic, an idea which might not be intuitive because their belief in God is so strong and because there may be some stigma or personal disappointment in admitting to low levels of spiritual well-being. Therefore, clergy may benefit from recognizing the need to cultivate their spiritual well-being across their years in ministry [34, 21].

Reducing occupational distress is important for religious entities, including numerous Christian denominations, because of the correlation of multiple types of clergy stressors with burnout [35, 36, 37]. The level of depressive symptoms of the clergy in this sample was higher than that observed in the general population [19], demonstrating a need to assess and respond to depressive symptoms in clergy. The assessment of depression and referral to therapeutic interventions may best be achieved through collaboration with mental health professionals [38].

Once recognized, there are many possible ways to promote one's spiritual well-being, including that of clergy. In a study of how pastors care for themselves, McMinn et al. [39] identified several common well-being practices among Christian clergy, including scripture reading, prayer, meditation/solitude, and connectedness to God, suggesting that many pastors

already know and sometimes use practices that likely promote their spiritual well-being. Recent initiatives have focused on encouraging Protestant clergy to keep Sabbath [40]. In addition, there are numerous spiritual retreat centers across the U.S. that provide space for Spiritual Renewal for Clergy.

Study Limitations

One limitation of this study of predominantly white, male, married and middle-aged North Carolina United Methodist clergy is the sample homogeneity, which may potentially limit the findings' generalizability. Another limit to generalizability is that the Clergy Occupational Distress Index (CODI) was created specifically for clergy, so may not apply to individuals in other helping professions. The results also may not apply to clergy of other denominations. Among clergy, United Methodists are one of few denominations in which clergy are appointed to churches by supervisors, so some aspects of their distress may be specific to the limits on the length of service with an individual congregation. Because the Spiritual Well-Being scales were developed specifically for Methodist ministers, future research to replicate these longitudinal findings in clergy of different denominations and faiths, may need to modify the scales. The Spiritual Well-Being measure is limited to closeness to God and does not purport to measure all of the possible aspects of spiritual well-being, or even all of the possible aspects of closeness to God. Also, the PHQ-9 measures self-reported depressive symptoms and does not establish clinical diagnoses.

Advantages of Sample Homogeneity

This study's strengths include the use of a large sample similar in demographic characteristics. Specifically, having data from a relatively homogeneous population can be helpful in that it minimizes the possibility of other factors explaining the findings. From this perspective, the measures used in this study are a strength, because of their match to the population. In terms of spiritual well-being, religion research largely uses measures that are more generic, designed to be applicable across diverse populations. Diverse applicability may attenuate the strength of the relationships [17, 41, 12]. This study used a measure of spiritual well-being developed specifically for United Methodist clergy with shared religious education and subsequent vocabulary and theological traditions [21]. In this way, the ideas assessed were directly related to the lived experiences of the clergy surveyed [16, 18, 42], supporting the validity of the findings.

Conclusion

Clergy are leaders of communities, with responsibilities to help people when they are at their most vulnerable moments (e.g. bereavement). Therefore, when clergy are under occupational distress or are depressed, there are larger social implications, as the clergy are less able to provide support to others. This prospective study demonstrates the possible protective attributes of spiritual well-being against depressive symptoms among Methodist pastors, and the possibility of reducing future occupational distress by reducing depressive symptoms. These longitudinal findings may be used to develop and target future interventions for clergy, with a focus on sustaining spiritual well-being long-term and an overall goal of optimal occupational function.

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References

1. Schonfeld, I. S., & Chang, C. H. (2017). *Occupational health psychology*. New York, NY: Springer.
2. Upadaya, K., Vartiainen, M., & Salmela-Aro, K. (2016). From job demands and resources to work engagement, burnout, life satisfaction, depressive symptoms, and occupational health. *Burnout Research*, 3, 101–108. <http://dx.doi.org/10.1016/j.burn.2016.10.001>
3. Bonde, J. P. (2008). Psychosocial factors at work and risk of depression: A systematic review of the epidemiological evidence. *Occupational and Environmental Medicine*, 65, 438–445. <http://dx.doi.org/10.1136/oem.2007.038430>
4. Harvey, S., Joyce, S., Modini, M., Christensen, H., Bryant, R., Mykletun, A., & Mitchell, P. (2012). Work and depression/anxiety disorders—A systematic review of reviews. Melbourne, Australia: BeyondBlue. <https://www.beyondblue.org.au/docs/default-source/research-project-files/bw0204.pdf?sfvrsn4>
5. Theorell, T., Hammarström, A., Aronsson, G., Bendz, L. T., Grape, T., Hogstedt, C., ... Hall, C. (2015). A systematic review including meta-analysis of work environment and depressive symptoms. *BMC Public Health*, 15, 1–14. <http://dx.doi.org/10.1186/s12889-015-1954-4>
6. Harvey, S., Joyce, S., Modini, M., Christensen, H., Bryant, R., Mykletun, A., & Mitchell, P. (2012). Work and depression/anxiety disorders—A systematic review of reviews. Melbourne, Australia: BeyondBlue. <https://www.beyondblue.org.au/docs/default-source/research-project-files/bw0204.pdf?sfvrsn4>
7. Smith, T. B., McCullough, M. E., & Poll, J. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin*, 129, 614–636. <http://dx.doi.org/10.1037/0033-2909.129.4.614>
8. Ronneberg, C. R., Miller, E. A., Dugan, E., & Porell, F. (2016). The protective effects of religiosity on depression: A 2-year prospective study. *The Gerontologist*, 56, 421–431. <http://dx.doi.org/10.1093/geront/gnu073>
9. Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, 37, 710–724. <http://dx.doi.org/10.2307/1388152>
10. Ahles, J. J., Mezulis, A. H., & Hudson, M. R. (2016). Religious coping as a moderator of the relationship between stress and depressive symptoms. *Psychology of Religion and Spirituality*, 8, 228–234. <http://dx.doi.org/10.1037/rel0000039>

11. Bickerton, G. R., Miner, M. H., Dowson, M., & Griffin, B. (2015). Spiritual resources as antecedents of clergy well-being: The importance of occupationally specific variables. *Journal of Vocational Behavior*, 87, 123–133. <http://dx.doi.org/10.1016/j.jvb.2015.01.002>
12. Snibbe, A. C., & Markus, H. R. (2002). The psychology of religion and the religion of psychology. *Psychological Inquiry*, 13, 229–234.
13. Joiner, T. E. J., Perez, M., & Walker, R. L. (2002). Playing devil's advocate: Why not conclude that the relation of religiosity to mental health reduces to mundane mediators? *Psychological Inquiry*, 13, 214–216
14. Pargament, K. I. (2013). Spirituality as an irreducible human motivation and process. *The International Journal for the Psychology of Religion*, 23, 271–281. <http://dx.doi.org/10.1080/10508619.2013.795815>
15. VanderWeele, T. J. (2017). Religious communities and human flourishing. *Current Directions in Psychological Science*, 26, 476–481. <http://dx.doi.org/10.1177/0963721417721526>
16. Berry, J. W. (1989). Imposed etics-emics-derived etics: The operationalization of a compelling idea. *International Journal of Psychology*, 24, 721–735. <http://dx.doi.org/10.1080/00207598908246808>
17. Exline, J. J. (2002). The picture is getting clearer, but is the scope too limited? Three overlooked questions in the psychology of religion. *Psychological Inquiry*, 13, 245–247. http://dx.doi.org/10.1207/S15327965PLI1303_07
18. Milstein, G., & Manierre, A. (2012). Culture ontogeny: Lifespan development of religion and the ethics of spiritual counselling. *Counseling et Spiritualité*, 31, 9–30.
19. Proeschold-Bell, R., Miles, A., Toth, M., Adams, C., Smith, B., & Toole, D. (2013). Using effort-reward imbalance theory to understand high rates of depression and anxiety among clergy. *The Journal of Primary Prevention*, 34, 439–453. <http://dx.doi.org/10.1007/s10935-013-0321-4>
20. Proeschold-Bell, R. J., Swift, R., Moore, H. E., Bennett, G., Li, X., Blouin, R., . . . Toole, D. (2013). Use of a randomized multiple baseline design: Rationale and design of the Spirited Life holistic health intervention study. *Contemporary Clinical Trials*, 35, 138–152.
21. Proeschold-Bell, R., Yang, C., Toth, M., Rivers, M., & Carder, K. (2014). Closeness to God among those doing God's work: A spiritual well-being measure for clergy. *Journal of Religion and Health*, 53, 878–894
22. Kroenke, K., Spitzer, R., & Williams, J. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, 606–613. <http://dx.doi.org/10.1046/j.1525-1497.2001.016009606.x>
23. Spitzer, R., Kroenke, K., & Williams, J., & the Patient Health Questionnaire Primary Care Study Group. (1999). Validation and utility of a self-report version of PRIME-MD: The PHQ primary care study. *Journal of the American Medical Association*, 282, 1737–1744. <http://dx.doi.org/10.1001/jama.282.18.1737>
24. Frenk, S., Mustillo, S., Hooten, E., & Meador, K. (2013). The Clergy Occupational Distress Index (CODI): Background and findings from two samples of clergy. *Journal of Religion and Health*, 52, 397–407. <http://dx.doi.org/10.1007/s10943-011-9486-4>
25. Sherbourne, C. D., & Stewart, A. L. (1991). The MOS social support survey. *Social Science & Medicine*, 32, 705–714. [http://dx.doi.org/10.1016/0277-9536\(91\)90150-B](http://dx.doi.org/10.1016/0277-9536(91)90150-B)

26. Eagle, D. E., Miles, A. A., & Proeschold-Bell, R. J. (2017). The honeymoon is over: Occupational relocation and changes in mental health among United Methodist clergy. *Review of Religious Research*, 59, 31–45. <http://dx.doi.org/10.1007/s13644-016-0263-4>
27. Pargament, K. I. (2002). Is religion nothing but . . .? Explaining religion versus explaining religion away. *Psychological Inquiry*, 13, 239–244. http://dx.doi.org/10.1207/S15327965PLI1303_06
28. Büssing, A., Baumann, K., Jacobs, C., & Frick, E. (2017). Spiritual dryness in Catholic priests: Internal resources as possible buffers. *Psychology of Religion and Spirituality*, 9, 46–55. <http://dx.doi.org/10.1037/rel0000063>
29. Bookwala, J., Marshall, K. I., & Manning, S. W. (2014). Who needs a friend? Marital status transitions and physical health outcomes in later life. *Health Psychology*, 33, 505–515. <http://dx.doi.org/10.1037/hea0000049>
30. Harrison, J., Barrow, S., Gask, L., & Creed, F. (1999). Social determinants of GHQ score by postal survey. *Journal of Public Health*, 21, 283–288. <http://dx.doi.org/10.1093/pubmed/21.3.283>
31. Proeschold-Bell, R. J., Eisenberg, A., Adams, C., Smith, B., Legrand, S., & Wilk, A. (2015). The glory of god is a human being fully alive: Predictors of positive versus negative mental health among clergy. *Journal for the Scientific Study of Religion*, 54, 702–721. <http://dx.doi.org/10.1111/jssr.12234>
32. Keyes, C. L. (2005). Mental illness and/or mental health? Investigating axioms of the complete state model of health. *Journal of Consulting and Clinical Psychology*, 73, 539–548. <http://dx.doi.org/10.1037/0022-006X.73.3.539>
33. Keyes, C. L. M. (2002). The mental health continuum: From languishing to flourishing in life. *Journal of Health and Social Behavior*, 43, 207–222. <http://dx.doi.org/10.2307/3090197>
34. Proeschold-Bell, R. J., & Byassee, J. (2018). *Faithful and fractured: Responding to the clergy health crisis*. Grand Rapids, MI: Baker Publishing Group.
35. Adams, C. J., Hough, H., Proeschold-Bell, R. J., Yao, J., & Kolkin, M. (2017). Clergy burnout: A comparison study with other helping professions. *Pastoral Psychology*, 66, 147–175. <http://dx.doi.org/10.1007/s11089-016-0722-4>
36. Francis, L. J., Village, A., Robbins, M., & Wulff, K. (2011). Work-related psychological health among clergy serving in the Presbyterian Church (USA): Testing the idea of balanced affect. *Review of Religious Research*, 53, 9–22. <http://dx.doi.org/10.1007/s13644-011-0003-8>
37. Visker, J. D., Rider, T., & Humphers-Ginther, A. (2017). Ministry-related burnout and stress coping mechanisms among Assemblies of God ordained clergy in Minnesota. *Journal of Religion and Health*, 56, 951–961. <http://dx.doi.org/10.1007/s10943-016-0295-7>
38. Milstein, G., Manierre, A., & Yali, A. M. (2010). Psychological care for persons of diverse religions: A collaborative continuum. *Professional Psychology, Research and Practice*, 41, 371–381. <http://dx.doi.org/10.1037/a0021074>
39. McMinn, M. R., Lish, R. A., Trice, P. D., Root, A. M., Gilbert, N., & Yap, A. (2005). Care for pastors: Learning from clergy and their spouses. *Pastoral Psychology*, 53, 563–581. <http://dx.doi.org/10.1007/s11089005-4821-y>
40. Sleeth, J. M. (2012). *24/6: A prescription for a healthier, happier life*. Carol Stream, IL: Tyndale House Publishers.
41. Hill, P. C., & Pargament, K. I. (2008). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *Psychology of Religion and Spirituality*, 1, 3–17. <http://dx.doi.org/10.1037/1941-1022.S.1.3>

42. Pike, K. L. (1967). *Language in relation to a unified theory of the structure of human behavior*. Berlin, Germany: De Gruyter Mouton. <http://dx.doi.org/10.1515/9783111657158>

Table 1
 Characteristics of the Sample at Baseline (n=895)

Sample Characteristics		
Demographic Characteristics		Value
Mean Age (sd)		51.5 (9.9)
No. White (%)		807 (90.2%)
No. Black (%)		46 (5.1%)
No. Other (%)		42 (4.7%)
No. Female (%)		273 (30.5%)
No. Married (%)		801 (89.5%)
No. w/ Master's Degree or More Education (%)		747 (83.5%)
Appointment Characteristics		
No. Full-time (%)		725 (81.0%)
No. Changed Churches 2010 to 2011 (%)		145 (16.2%)
Personal Characteristics:		
Mean Score Depressive Symptoms	(sd) (Range: 0 - 27)	4.3 (4.2)
Mean Score Occupational Distress	(sd) (Range: 0 - 15)	6.6 (3.0)
Mean Score Spiritual Well-Being, Everyday	(sd) (Range: 0 - 24)	15.4 (4.8)
Mean Score Spiritual Well-Being, Ministry	(sd) (Range: 0 - 24)	16.3 (4.6)
No. Fair or Poor Self-Rated Health (%)		130 (14.5%)
No. Extreme, Very, or Moderate Self-Rated Financial Stress (%)		406 (45.4%)
Mean Score Perceived Emotional Support	(sd) (Range: 0 - 32)	24.1 (5.9)
Design Variable		
No. Intervention Group (%)		290 (32.4%)

Table 2

Correlations among depressive symptoms, occupational distress and spiritual well-being, at baseline (n=895).

	Occupational Distress	Spiritual Well-Being Everyday	Spiritual Well-Being in Ministry
Depressive Symptoms	0.5134****	- 0.2883****	- 0.1963****
Occupational Distress		- 0.1963****	- 0.1920****
Spiritual Well-Being in Everyday			0.7355****

**** p < .0001

Table 3
Occupational Distress and Spiritual Well-Being (SWB) in both Everyday (Model 1) & Ministry (Model 2) at baseline, predicting Depressive Symptoms one year later (n=895)

Parameter	Model 1 - Everyday			Model 2 - Ministry		
	Estimate ¹	Std Error	p	Estimate ¹	Std Error	p
Depressive symptoms	0.4938	0.0340	****	0.5080	0.0339	****
Occupational Distress	0.0071	0.0334		0.0049	0.0337	
SWB, Everyday	-0.1137	0.0300	***			
SWB, Ministry				-0.0588	0.0291	*
Age	-0.0313	0.0283		-0.0358	0.0285	
Female	0.1398	0.0632	*	0.1243	0.0634	*
Black	-0.1950	0.1246		-0.2157	0.1255	
Other Ethnicity	-0.1692	0.1283		-0.1819	0.1290	
Full-Time	0.0296	0.0812		0.0261	0.0817	
Changed Churches 2010-2011	-0.2164	0.0751	**	-0.2172	0.0756	**
Married	0.1816	0.0943		0.1860	0.0951	
Master's Degree or More	0.0256	0.0829		0.0414	0.0834	
Intervention Group	-0.1338	0.0577	*	-0.1432	0.0580	*
Fair/Poor Self-Rated Health	-0.0198	0.0808		-0.0033	0.0812	
High Financial Stress	0.0635	0.0585		0.0739	0.0588	
Perceived Emotional Support	-0.1193	0.0297	****	-0.1364	0.0295	****

*p<0.05, **p<0.01, ***p<0.001, ****p<0.0001

¹Standardized regression coefficient

Table 4

Depressive Symptoms and Spiritual Well-Being (SWB) in both Everyday (Model 1) & Ministry (Model 2) at baseline, predicting Occupational Distress one year later (n=895)

Parameter	Model 1 - Everyday			Model 2 - Ministry		
	Estimate ¹	Std Error	p	Estimate ¹	Std Error	p
Occupational Distress	0.4621	0.0320	****	0.4583	0.0320	****
Depressive Symptoms	0.1478	0.03266	****	0.1469	0.0323	****
SWB, Everyday	-0.0113	0.0277				
SWB, Ministry				-0.0438	0.0277	
Age	-0.1403	0.0271	****	-0.1370	0.0271	****
Female	0.1095	0.0606		0.1115	0.0603	
Black	-0.0303	0.1194		-0.0126	0.1194	
Other Ethnicity	0.0884	0.1229		0.0945	0.1227	
Full-Time	0.1438	0.0778		0.1460	0.0777	
Changed Churches 2010-2011	-0.0911	0.0720		-0.0917	0.0719	
Master's Degree or More	0.1833	0.0795	*	0.1746	0.0793	*
Married	0.0633	0.0904		0.0523	0.0905	
Intervention Group	-0.0199	0.0553		-0.0221	0.0552	
Fair/Poor Self-Rated Health	-0.1399	0.0774		-0.1468	0.0772	
High Financial Stress	0.0742	0.0560		0.0761	0.0559	
Perceived Emotional Support	-0.0640	0.0285	*	-0.0582	0.0280	*

*p<0.05, **p<0.01, ***p<0.001, ****p<0.0001 ¹Standardized regression coefficient

Table 5

Depressive Symptoms and Occupational Distress at baseline predicting Spiritual Well-Being (SWB) in both Everyday (Model 1) & Ministry (Model 2), one year later (n=895)

Parameter	Model 1 - Everyday			Model 2 - Ministry		
	Estimate ¹	Std Error	p	Estimate ¹	Std Error	p
SWB, Everyday	0.6198	0.0273	****			
SWB, Ministry				0.6086	0.0271	****
Depressive Symptoms	-0.0094	0.0309		-0.0103	0.0315	
Occupational Distress	0.0571	0.0304		0.0251	0.0313	
Age	0.0629	0.0258	*	0.0368	0.0265	
Female	0.0541	0.0575		0.0675	0.0590	
Black	0.3401	0.1134	**	0.2586	0.1167	*
Other Ethnicity	0.3214	0.1168	**	0.3075	0.1200	*
Full-Time	-0.0507	0.0739		-0.1079	0.0759	
Changed Churches 2010-2011	0.0743	0.0684		0.1657	0.0703	*
Married	-0.1049	0.0859		0.0084	0.0884	
Master's Degree or More	-0.0807	0.0755		-0.0894	0.0775	
Intervention Group	-0.0127	0.0525		0.0811	0.0539	
Fair/Poor Self-Rated Health	-0.0388	0.0736		-0.0798	0.0755	
High Financial Stress	-0.0162	0.0532		-0.0349	0.0547	
Perceived Emotional Support	0.0937	0.0271	***	0.0861	0.0274	**

*p<0.05, **p<0.01, ***p<0.001, ****p<0.0001

¹ Standardized regression coefficient