

# Different health-related experiences among four kinds of United Methodist Church pastors

*Female pastors, young pastors, local pastors, and large church pastors*

---

Sara LeGrand, Rae Jean Proeschold-Bell, John James, and Amanda Wallace  
Duke University

Please direct comments to Rae Jean Proeschold-Bell at [rae.jean@duke.edu](mailto:rae.jean@duke.edu).

## Abstract

Studies finding high rates of chronic disease among clergy have called for the design of clergy health interventions. However, among clergy there is substantial diversity. We conducted four focus groups with a cross-section of United Methodist clergy. Preliminary data analysis led us to add one focus group each with female, local, young, and large-church pastors. We compared themes from the specific focus groups to themes from the four broader focus groups. Findings include: female pastors feeling guilty for taking personal time and experiencing pressure to prove themselves; local pastors reporting financial strain and highly valuing a variety of interpersonal relationships; young pastors indicating child-related stress but also greater interest in nutrition, exercise, and promoting health through the church; and large-church pastors expressing increased confidence in negotiating personal time off and reporting more sharing of pastoral duties. We organized themes by levels of the Socioecological Framework to guide intervention design.

*Keywords: Clergy; health; intervention; ecological*

This is a pre-peer reviewed version of the following article: LeGrand, S., Proeschold-Bell, R.J., James, J., & Wallace, A. (2012). Healthy leaders: Multilevel health promotion considerations for diverse United Methodist Church pastors. *Journal of Community Psychology*, which has been published in final form at <https://doi.org/10.1002/jcop.21539>.



# Introduction

## The Clergy Vocation

Clergy occupy a unique role in our society. Clergy are leaders for their congregations, and often they take on broader community leadership roles. A closer look at the work of clergy reveals that its essence is worship, preaching, teaching, and oversight of the congregation (Carroll, 2006). However, diverse and multiple tasks emanate from this work. The roles of clergy have been divided into interpersonal roles (e.g., leading or acting as liaison); informational roles (e.g., disseminating information); decisional roles (e.g., handling conflict and determining how to allocate resources); and professional roles (e.g., care giving, mentoring, and preaching) (Kuhne & Donaldson, 1995).

## Clergy Health

Until recently, little was known about the health of modern-day clergy (in this paper, we define health holistically as physical health, mental health, and spiritual well-being). Regarding clergy health prior to 1950, a compilation of standardized disease rates among clergy in Europe and the United States (US) from the 1600s to 1950 indicated longer longevity among clergy than their non-clergy counterparts (King & Bailar, 1969). This advantage appears to be due to behaviors leading to fewer accidents and suicides, rather than to lower rates of chronic diseases; for example, the same study also examined specific disease mortality rates and found higher cardiovascular disease mortality among clergy than their non-clergy peers (King & Bailar, 1969). A 2001 study of clergy from the Evangelical Lutheran Church in America found that 68% of survey participants were overweight or obese, in comparison to 61% of Americans, although the study did not adjust for population differences like age and gender (Halaas, 2002). Most recently, in a 2008 study of United Methodist clergy that did adjust for demographic population differences, Proeschold-Bell and LeGrand (2010) found that clergy had higher rates of obesity, diabetes, arthritis, high blood pressure, and asthma than non-clergy. Thus, at least some groups of clergy are experiencing obesity and chronic diseases at high rates.

In terms of mental health, clergy experience a number of stressors, such as frequent moves, financial strain, lack of social support, high time demands, and intrusions on family boundaries (Morris & Blanton, 1994). Lee and Iverson-Gilbert (2003) have conceptualized the antecedents of pastoral stress as emanating from four categories: personal criticism, boundary ambiguity, presumptive expectations, and family criticism. At their heart, these stressors are relational in nature.

## Ecological Theories of Health

Community psychologists have long-recognized the role that environments play in human behavior. For example, community psychology has been heavily influenced by the work of Kurt Lewin (Lewin & Cartwright, 1951), who developed the study of environments on individuals (Ecological Psychology), and Urie Brofenbrenner (1979) who proposed three levels of environmental influence on the individual, namely, microsystems (interactions among family members and small groups), mesosystems (physical settings for school, work, and family life), and exosystems (large social systems such as politics and culture). This emphasis on the ecological perspective has been extended from the understanding of human behavior to intervention development; it is essential to understand the local context at multiple levels when creating interventions (Kelly, 2006; Trickett, 2009).

Multilevel, ecological theories are therefore important to understanding clergy health. Proeschold-Bell and colleagues (2009) considered the influence of clergy circumstances on coping and health practices, such as

exercise, food selection, engagement in spiritual activities, and receipt of mental and physical health care, which are ultimately associated with health outcomes. In their analysis of clergy circumstances, Proeschold-Bell and colleagues adapted the Socioecological Framework (McLeroy, Bibeau, Steckler, & Glanz, 1988), a theory of environmental levels of influence on health.

The Socioecological Framework starts with the “intrapersonal” level of influence, defined as an individual’s beliefs and attitudes, as well as demographic characteristics such as gender. In prior research, intrapersonal conditions related to stress, self-care, or health outcomes among clergy included work satisfaction, burnout, emotional exhaustion, self-assessment of success, and personal boundaries (Lee & Iverson-Gilbert, 2003; Meek et al., 2003; Morris & Blanton, 1994; Proeschold-Bell et al., 2009; Rowatt, 2001). The second level is interpersonal, namely, relationships with spouses, family, and close friends. The literature indicates that support from families, satisfaction with family life, support from other pastors, and support from friends are related to clergy health (Meek et al., 2003; Morris & Blanton, 1994; Proeschold-Bell et al., 2009; Rowatt, 2001). The third level is that of community. Congregations are an important community for clergy and have been recognized for their role in influencing clergy health. For example, the degree of criticism congregants exact on a pastor is often identified as an important predictor of clergy stress, satisfaction, and health (Lee & Iverson-Gilbert, 2003; Proeschold-Bell et al., 2009; Rowatt, 2001). More broadly, the overall functioning and health of the congregation is perceived by clergy to affect health outcomes among pastors (Proeschold-Bell et al., 2009). Finally, for our purposes, the Socioecological Framework highlights the effects of institutional factors on health. For clergy, the institutional level may be represented by denominational practices, like stratification by clergy ordination status and the process of matching pastors to congregations. Thus, in our effort to understand clergy health, the levels of influence specific to clergy are helpful, as are factors that researchers have identified as relating to clergy health.

When we embarked on designing a health intervention for clergy, we began with focus groups to learn directly from clergy themselves about barriers to, and facilitators of, their health. During analysis of these data, we thought we heard different themes from four kinds of clergy: female pastors, large-church pastors, young pastors, and local pastors. We therefore held an additional focus group with clergy of each of these demographic groups to examine whether particular health-related experiences are more salient for them than for clergy in general. This paper reports on differences found between the themes arising from the initial four focus groups with a cross-section of clergy and the themes arising from each demographically specific focus group. We believe that a more thorough understanding of the health-related experiences of different kinds of clergy and at each level of the Socioecological Framework will help inform the development of health interventions for clergy.

## Methods

### Data Collection

We conducted four initial pastor focus groups (N=33) with heterogeneous samples of United Methodist Church (UMC) pastors in North Carolina in January and February 2008. We recruited participants evenly from the two UMC conferences in the state, with attention to age, gender, race, and rurality. From the total sample, 63.6% of the participants were male and 36.4% female, 12% were age 21-40, and 84.8% were age 41-70, 36.4% were licensed local pastors and 51.5% were Elders, 90.6% were Caucasian, 6.3% were African American, and 3.1% were Latino. Clergy were identified using a published conference roster and were invited to participate by phone or email. The semi-structured to unstructured focus group questions collected information about participants’ conceptualization of health, barriers to and facilitators of health, and the perceived relationship

between the congregation and the health of the pastor. Consistent with the grounded theory approach (Strauss & Corbin, 1990) we initiated data analysis during the data collection process. Based on initial analyses, we determined that specific groups of clergy may have different health-related experiences. In order to investigate further these potential differences, we used theoretical sampling (Creswell, 1998) to recruit individuals who represented the demographic groups of interest. Four additional focus groups were held in May and June 2008. These groups consisted of female clergy (n=6), licensed local pastors (n=6), pastors under the age of 35 (n=7), and clergy from large churches (n=7). We chose age 35 because 14% of UMC clergy in the two North Carolina conferences were age 35-44, but only 6% were age 18-34. We defined large churches to be those of sufficient size to have more than one pastor on staff. The clergy who attended this focus group included some senior pastors and some associate pastors, representing churches ranging in size from 600 to 4,000 members. We allowed participants in these additional focus groups to possess characteristics of clergy in the other focus groups. For example, three young women participated in the young clergy focus group. We allowed for this overlap because to deny young women clergy the opportunity to describe the health-related experiences of young clergy would have resulted in a male-focused young clergy experience and ultimately would have systematically biased the sample of young clergy. Table 1 reports the demographic overlap between participants in each of the four focus groups.

Focus groups were 60-90 minutes in length and were audiotaped and transcribed. Participants were asked to fill out a short demographic survey at the conclusion of the focus group. Lunch and travel reimbursements were offered as compensation. The study was approved by the Duke University Institutional Review Board and all participants gave signed consent.

### **Data Analysis**

Regularities and patterns in the data were identified in an iterative process of data analysis, which was initiated by the four-person research team immediately after the start of data collection. Coding categories, which emerged from the data rather than from pre-existing hypotheses (Charmaz, 2001), were developed and transcripts were coded using Atlas.ti version 5.2 (Muhr & Friese, 2004). To promote confirmability (M. Miles & Huberman, 1994), two members of the research team coded each transcript and reached consensus through discussion about any discrepancies (Miles & Huberman, 1994). We examined units of data from each code for integrated schema, known as pattern coding. To understand differences between subgroups of clergy, we compared the themes of the four general focus groups to the themes of each of the subgroups, and highlighted the differences. All research team members had to agree that a theme for the subgroup was different in order for us to include it in the results.

## **Results**

When compared to the overall sample of focus group participants, unique themes were detected in each of the four specialty focus groups. We categorized these themes into the Socioecological Framework levels of intrapersonal, interpersonal, congregational, and institutional conditions. The highlights of these findings are provided below.

### **Female Clergy**

**Intrapersonal.** Female clergy, who comprise 25% of UMC pastors in NC, reported that gender expectations have a marked impact on their lives as pastors. Although many focus group participants reported a tendency to put everyone else's needs before their own, the female pastor focus group data suggested that this

is often more pronounced among women because of the default role of women as the caretaker of the family and the congregation. According to one focus group participant:

*And you will get physically sick. ... If you don't take your time and you don't rest your body then you're going to experience stress. And I think, as women, one thing that sets us apart, too, is most of us have families. ... I spent years as a single mom with the responsibilities of a single mom on top of that and trying to make time to be with my family and letting folks understand that with the family situation. So, that's hard because we are the nurturers for them as well as usually the nurturers in the church.*

Female pastors also noted difficulties setting boundaries to protect personal time. In discussions about time off and vacations, feelings of guilt were frequently expressed by female clergy:

*But I think we worry so much and we don't take that time. When that time comes, we're thinking, "What about this and what about that? I can't get away then." And like [she] said, we need to reaffirm each other in that as opposed to adding more guilt. Instead of saying, "Well, how can you do that? How do you get away for two weeks? I can't do that!" And then I'm sitting there thinking, "What, am I a terrible person because I take my vacation?"*

**Interpersonal.** Many clergy suggested that friendships with other clergy members are vital to their health and well-being because clergy peers share similar experiences that others may struggle to understand. However, the female focus group participants reported that female pastors may encounter challenges with these relationships because they want to prove themselves worthy of the pastorate. Female clergy may work diligently to maintain expected appearances, establish distance from feelings of vulnerability, and be reluctant to trust their peers—even female peers. One participant noted:

*I think we're concerned about being judged by another clergy person and our image changes to them. Or, if I reveal something that someone is going to think differently of me, if I'm honest about something.*

Trust and confidentiality were concerns for female focus group participants. They perceived a lack of “safe places” to go among their clergy peers in the UMC conference to share emotional problems:

*I have seen [confidentiality] be broken within even covenant groups and things. ... And I feel cut off many times. I feel lonely. Of course it makes me closer to Jesus because I'm going to go to Him. And we should, first and foremost. But it would be nice to have somebody that you could have that kind of trust with and that kind of bond with but I'm always worried about confidentiality. ... And that's the spiritual and emotional health. You need to have that person. The bishop said the other day in that meeting, "Find a person that you can be in covenant with and call and talk to over the weeks of your transition." And I looked and looked and couldn't write a name down of another pastor. ... I couldn't come up with one name that I thought that I absolutely could spill my guts about all of it. ... I wrote "Jesus" on my paper.*

**Congregational.** Other factors perceived to influence the health of female pastors were related to the relatively new ordination of women as UMC clergy, which began in 1956, and the lingering preference for a male pastor among some congregants. Compared to our other focus groups, participants in the female clergy focus group indicated that they feel increased pressure to work harder and perform better in order to prove themselves to congregants who would prefer a male pastor. In this case, congregational expectations around

clergy gender influence the degree of internal pressure experienced by female pastors:

*I think we, because we're women, we try so hard because, with the ordination of women being as young as it is still. .... Every [church] I've been I've heard the comment, "Well, we were hoping it was going to be a man." ... And I think you try and compensate, you overcompensate for that. Because you are female, you think, "I've got to work four times harder." Let me just say this--there are some sorry man preachers out there. Sorry. I mean sorry. But the thing is, a lot of the churches will say, they would rather have a sorry man, I think, than a hard-working woman. And so I think we end up killing up ourselves to try to be everything because we're thinking we want to down-live that, that they didn't want us. ... And I think that puts a stress on us that's different from the men.*

As part of the effort to gain respect from congregants, female clergy indicated the need to hide parts of their true selves at times:

*I want to be honest with my folks. That has been my saving point, I think, is because I tell people the truth and I'm not going to change up. But I think we start trying to hide who we are. ...We start losing some of that individuality because somebody will say, "You're not wearing a jacket when you preach?" "No! I'm wearing my sundress." ... I don't know, maybe it's just me, but I think people hide and I think women hide more than men.*

Furthermore, female clergy may feel it is necessary to defend the validity of their pastoral call to congregants because of theological objections to women in the pastorate:

*I was just going to say, like [another participant] was saying, it's God. I told them, "If I was not called by God, I wouldn't." They said, well, they'd never heard of a female pastor being called to preach. And they had mentioned Paul. And I said, "Well, Paul didn't call me to ministry. God did." And they said, "I've never heard a woman say that before." So, God is who I get my affirmation from.*

**Institutional.** Female participants perceived that some congregations openly resist accepting a woman as pastor. They expressed disappointment that the bishop or conference did not take a harder policy line in requiring that churches receive and affirm their duly appointed pastor regardless of gender:

*But why is that happening where [a church] can say... "we don't want a woman"? I've heard [the bishop] say you're going to be appointed regardless, but here again, who has got our back here?*

Thus, the female focus group data differed from that of the four general focus groups. Female pastors indicated that they put everyone else's needs before their own to a greater extent than other clergy, who already have this tendency; feel guilty for taking personal time; feel pressure to be excellent pastors in order to overcome anti-female pastor sentiment; and fear making themselves vulnerable even to peer pastors in order to preserve an image of excellence and protect against breaches of confidentiality. The female pastors drew linkages between each of these themes and health. For example, participants stated that putting everyone else's needs first will get you "physically sick," and that being a minority (i.e., female) in this vocation creates stress and "we end up killing ourselves."

### **Local Pastors**

In the United Methodist Church (UMC), many congregations are led by licensed lay ministers, called "local pastors." Local pastors comprise 31% of UMC clergy appointed to congregations in North Carolina. Unlike elders in full connection, local pastors are not ordained and are usually not seminary trained. Although all UMC

pastors serve in an itinerant polity and are appointed to their churches by the bishop, local pastors tend to itinerate less widely than elders and are more likely to be longtime residents of the communities where they minister. While elders are normally guaranteed a full-time appointment every year, local pastors receive no such assurances. Appointments of local pastors are made depending on the needs of the conference and are more likely to be part-time and at a lower salary.

**Intrapersonal.** Local pastors mentioned financial struggles and their relation to health more frequently than participants of the general focus groups. They expressed particular concern about their inability to afford health-promoting goods and services and voiced hopes that the conference might offer programs to subsidize health-related expenses:

*[M]y wife and I are living on a shoestring budget. You have to realize, bad food is really cheap and good food like organic is really expensive, so maybe there could be some kind of offset for buying fresh produce.*

*I know how much counseling costs. That would not be pretty on a clergy salary. And a secular counselor cannot help you with church issues.*

Although we ultimately chose to categorize financial strain as an intrapersonal condition based on the idea that financial status is an individual-level experience, we could easily have categorized it as an institutional condition based on the UMC system which often assigns local pastors to churches that can only afford a small salary for pastors.

**Interpersonal.** Compared to the larger sample of participants, local pastors indicated a stronger reliance on interpersonal support from other clergy members and non-clergy friends and family. Examples of remarks made by local pastors about the need for support include:

*We have a covenant group and we can talk about our health issues and just like in Vegas, it stays there. I can call on them anytime. ...There is an outlet. My husband and I asked about one when we moved there. If you don't have one, start one up.*

*I also think that it's important to have peers outside who aren't clergy - friends and family who aren't clergy is helpful.*

**Congregational.** Local pastors recognized strong congregational expectations around the visibility and constant availability of pastors and the wives of male clergy. The participants voiced concerns about the resulting impingements on free time, and thus the lack of time available for health practices and personal relationships:

*A lot of members just want to see you when they want to see you. Like in the church office. They might not need you but they want to see you.... "Where were you?"*

*Christ got away to the mountain to pray. My wife and I get away and Friday night is our Sabbath - we gather with friends or alone.... It is a problem with the church because we are not visible enough. They actually wanted my wife to quit her job.*

*There is still the expectation that the spouse is the [full-time volunteer]. ...When a couple lived on one salary, things were different--now that is really unfair [for the church to expect the spouse to be an unpaid volunteer].*

Local pastors differed from the larger focus group sample in heightened attention to financial strain and the resulting lack of access to health-promoting products and services such as healthy foods, counseling services, and retreat opportunities. In addition, local pastors discussed the need for strong interpersonal relationships with other clergy, friends, and family more frequently than the broader sample of focus group participants. In part, these relationships were deemed important because they allowed a venue for discussion about health issues. Finally, the higher congregational expectation for clergy and female spouse visibility resulted in concerns about health practices among local pastors. No specific institutional level themes arose.

### Young Pastors

**Intrapersonal.** The focus group conducted with pastors under the age of 35 also revealed distinct experiences related to health. Young pastors identified financial limitations as a potential barrier to optimal health with more frequency than the overall sample. Newly ordained pastors typically have lower salaries than those who are older and have served longer, and age is correlated with length of time since ordination. As a result, health-related activities such as purchasing healthy foods and utilizing medical services may be a financial stretch for young pastors. For example, young focus group participants perceived difficulties in affording mental health care:

*Participant 1: Medical benefits for mental illness in the [UMC] conference are sorry. And when you're in a vocation that probably has that risk almost more than maybe any other vocation out there, really if you think about it, those should be, just numerically, those should be very good benefits. You shouldn't have to pay - I don't know, no telling what it is lately.*

*Participant 2: Twenty or thirty [dollars]. It was more than that, I think. It was like 30 bucks. And if you are a pastor and you're a young pastor and your wife doesn't work, 30 bucks a week, that's huge.*

**Interpersonal.** Young pastors discussed concerns about identifying peers whom they could rely on for support and trust with confidential health information. For example, one participant stated:

*I think some of the emotional health issues too, ... where do you go with that? Who do you trust that you can go to and talk about that and get some help with that? Because it's hard to know who to trust. You're not going to people in your church most of the time. You're not going to go to other pastors a lot of the time. ... Who do you go to and what do you do with it? And I think that that's a big issue.*

Although young pastors may have concerns about trusting others, there was general support for the role peers can play in enhancing clergy health. Some young pastors felt that official clergy gatherings were often dull or artificial. There was particular interest in gathering to have fun and “blow off some steam” instead of focusing on work-related development:

*At Annual Conference this year, we're actually going to attempt to do kind of the first young clergy gathering at Conference. And we're just - that's the thing, there's no agenda. Like, we're not talking about, "Here is a book you all need to read." Or, "Here are six practices you need to do in your congregation." I mean, we're getting together, we're eating and we're playing video games. Like, that's all that's on the agenda.*

**Congregational.** Young pastors were also the most attuned to health issues, including the importance of a healthy diet and exercise. Several young pastors acknowledged the challenges associated with eating



healthfully when foods offered at church functions are often unhealthy. One pastor described his strategy for coping with the church food culture:

*I don't eat at covered dishes anymore. If there is a meal at church I come and I fellowship with everybody and then I go and eat either at home or eat something. And I think that's very unusual. And people say, "Aren't you going to eat? Aren't you going to eat?" And I'm like, "No. I'm good."*

In addition to being more personally cognizant of health-related issues, young pastors were more likely to recognize health problems among congregants and the poor health norms that exist in the community. A conversation between two participants provides an example of the attentiveness of young clergy to congregant health challenges:

*Participant 1: People call it "the sugar", but it's diabetes. "The sugar" is diabetes and very few people realize that it's their diet that has brought on this diabetes. Most of the time it's not hereditary, it's just the diet of biscuits and gravy.*

*Participant 2: And then you get, "I have sugar so I can only eat one donut." [laughter] No one in my congregation sticks to the diet that they're supposed to be on.*

Unlike other clergy groups, young pastors discussed the unrealized potential of churches as a venue for health promotion efforts:

*But it seems like the local church would be the perfect venue to create programs for people to do with health. You know, as far as weight and exercise and that kind of stuff. It's tailor-made really in a lot of ways. There's no other organization in all of the United States that could facilitate that better than local church congregations, and we don't do anything. I mean, when is the last time any of us preached a sermon on gluttony except maybe mentioning it as a sarcastic, funny comment. I mean, I do that sometimes in a sermon, but not to really say, "Your body is your temple. How are you treating it? Are you sinning by doing this?" But, my Lord, talk about really getting run out of a church.*

Young pastor focus group participants reported that a congregational condition that may influence their health is related to having children. They indicated that congregants may pressure young clergy families to have children and may not respect the couple's privacy about the decision:

*And then back to the baby thing, too. Being a female minister, ever since we got married. ... "When are you having babies?" And everybody in the church, especially all the women, everybody in the church asks me that at least once a day. ... They don't ask, "Do you want to have children? Are you able to have children? It's none of my business, I'm going to ask anyway." It's just, "When are you having babies? You better get started. You all have been married now two years. What are you doing?"*

Some young clergy noted that congregants sometimes feel a sense of ownership over clergy children, particularly babies. One participant noted:

*I know those first few months had to be horrible for [pastor's wife]. I mean, people in and out of the house. People wanting to see the [twin] babies so badly and everybody wanting to hold them. And all the germs going around and all that. You just don't hand babies around like you hand around pictures. And then they become the church's babies and that was really tough.*

**Institutional.** One topic of interest for the young pastors group was an emerging conference program of mandatory peer-support groups among clergy. Several participants expressed their disdain for assigned peer

groups, arguing that relationships among clergy should be allowed to unfold naturally.

*Well, from my own personal experience [with] mentoring or accountability groups, the buzz about it is that you're just going to be told who you're going to be with and the formula that I think that they're using as a tool to put people together may not be the same formula that I would use to pick somebody to do something with or to be accountable with.*

*The conference is starting this mentoring peer accountability group thing which I think is good in theory, but I already have my peers. I already have a group that I'm accountable to and I don't want it mandated by my district superintendent.*

Young pastors also expressed distrust in discussion about difficult and sensitive topics with their immediate supervisor, the district superintendent (DS). DSs evaluate pastors' performance and advise the bishop on future ministry assignments. The young clergy were keenly aware of the possibility that sensitive health information, particularly related to mental health challenges, shared with their DS may have a negative impact on future appointments:

*Oh, yes. If you're having an emotional issue, technically your district superintendent is your pastor but he's also your boss. And it's really hard to find a place where you can deal with some of your emotional issues and feel like it's being held in confidence. I have not personally experienced that, but I'm very guarded about what I tell my district superintendent because I know it's fair game at Cabinet meeting.*

In sum, compared to the overall focus group sample, young pastors indicated feeling more financial strain, resulting in concerns about the ability to eat healthfully and utilize needed health services. Young clergy were generally more aware of the importance of proper nutrition and exercise and identified strategies they use to protect their health in the church setting. They were also more mindful of the health of their congregations and recognized the potential for improving the health of congregants through church-based activities. Young pastors recognized that peers can provide an opportunity to discuss relevant health issues and relieve stress, but expressed more concerns about the trustworthiness of their peers than the overall sample. Participants reported additional stress related to children. Finally, young clergy were apprehensive about sharing sensitive health information with their supervisors for fear of career repercussions.

### **Large-Church Pastors**

**Intrapersonal.** Female, local, and young focus group participants often identified challenges to health resulting from stress or barriers to coping and positive health behaviors. However, large-church pastors, which comprised 24% of UMC clergy in NC, provided examples of how they are able to reduce stress, enhance coping, or improve health practices:

*So, taking a spiritual retreat. Since the beginning of my ministry I've taken fifth Sundays off for a retreat, renewal, rest, rejuvenation. And that's been a great practice because then I know I have that time to focus on my spiritual life and carving it out for that and not thinking, "Oh, well, I'll get around to that. I don't know if I'll make it this year or next year."*

*The other thing that keeps occurring to me is that I don't want the DS [district superintendent] or I don't want Staff Parish [Relations Committee] telling me when I*

*need time off. I want to tell them. And I want to know myself well enough to say, "Hey, listen. Here's how I operate. And this is what it takes for me to be effective." And I don't think that needs to be antagonistic. I don't think that needs to be two sides coming at each other. I think you're expressing this is my need. Just like I need food every day and I need this kind of time.*

Analysis of the focus group data also revealed that clergy of large churches were more knowledgeable about their options and rights regarding vacation time and were more empowered to take this time.

**Interpersonal.** Pastors of large churches more frequently expressed positive opinions about interpersonal relationships with their peers. Several participants credited a clergy group for their survival in the ministry during significant career hardships:

*You know, it's just a unique situation and I began feeling more and more and more isolated and oh gosh, I think I'm going to cry. In a hard place. And there's nobody else that knows what we do than other clergy. So... I had worked with a lot of clergy through the years and finally, about two years ago I said to a group one time on the weekend, "I need you. Will you be there for me?" And they have been. And it's been salvation for me.*

**Congregational.** Analysis revealed much less anxiety among large-church pastors about congregational-level conditions, and more good humor and acceptance of inevitable minor stresses. These pastors discussed skills in pushing back against congregational demands and in knowing when their presence was vital and when it was not:

*And sometimes I think it's okay to put other stuff on the back burner if you've got a series of funerals. You've got a congregation with a lot of older people, you've got to put some of that programming back for a while until you can get to it. And just let the people know, "This is where I'm at. We'll get to it, or you can take it."*

A pastor's lack of privacy was cited as a difficult issue. For instance, pastors voiced negative comments about living in a parsonage, which the local church owns and manages:

*The parsonage system ... for us, has been the most difficult aspect of ministry. It really has been the parsonage, I think for that reason: it's not your home.... [It is] run by a committee.*

**Institutional.** An institutional factor that may allow some large-church clergy to protect personal time is the ability to share the workload with other staff members. As one pastor explained, "We have Fridays off, we rotate and all that kind of stuff."

Pastors of large churches had a number of specific ideas about how institutional structures could be changed to support clergy self-care throughout the conference:

*I wish we had – if a third party could work more closely with the incoming pastor. Of if maybe the pastor is already there, then the staff parish committee. What is the cycle? What is expected for study and for family leave? And advocate to work out a deal, to work out a process.... I think our system has some really good qualities, but when you have a Diocese or a Presbytery negotiating as a third party and setting that in place, I imagine that would help because it takes the emotion out of both sides.*

This pastor draws on terms and examples (*diocese* and *presbytery*) from mainline denominations other than the UMC. This suggests that large-church clergy may have greater exposure to non-Methodist leadership structures, and may be able to draw on a wider range of solutions, than the pastors of smaller UMC congregations.

Clergy of large churches differed from the overall study sample in their expression of confidence in their ability to negotiate time off because of the size of the church staff. These pastors were also more informed

about vacation benefits and more frequently reported taking vacation. Participants discussed the importance of vacation time to their emotional and spiritual health. Clergy of large churches reported that relationships with other clergy were important for coping with the hardships associated with the job and, unlike the larger sample, they rarely indicated distrust or dissatisfaction with peer relationships. They were more skilled at coping with demands from the congregation and defining the pastor's role for themselves, not assuming the role(s) as defined by their members. Large-church pastors had imaginative ideas about reforming institutional structures to support clergy self-care, with particular concern for pastors at risk of burnout or overwork.

## Discussion

This study allowed for identification of intrapersonal, interpersonal, congregational, and institutional conditions that are perceived to influence the health of female pastors, local pastors, young pastors, and large-church pastors. Identification of these factors may support the design of clergy health interventions to meet the needs of subgroups of clergy. Although it may not be practical to design separate health interventions for each clergy subgroup studied here, but it may be possible to weave this deeper understanding into aspects of a broader clergy health intervention. For example, in 2011 we launched a clergy health intervention called Spirited Life. Spirited Life is multi-faceted, but among its dimensions are monthly phone calls between clergy and a Wellness Advocate who helps with health goal-setting and resource-finding. Wellness Advocates can utilize an understanding of health issues for each of these clergy subgroups when seeking to meet the needs of individual clergy. Also, it may sometimes be possible to design a health intervention for a specific subgroup of clergy. To that end, we organized the Results section into the ecological levels of the Socioecological Framework to facilitate intervention design by subgroup and ecological level.

There is a growing literature on female pastors and it is interesting to compare our health-specific findings to general themes found by other researchers. For example, although some prior research has suggested that female clergy may receive more social support, including support from congregations, peers, and institutions, than male clergy (McDuff & Mueller, 1999), our findings were similar to the those of Rowatt (2001) in which female clergy report loneliness resulting from a lack of relationships. Because female clergy aim to prove their worthiness and competence to their church leaders, peers, and congregants, they do not want to display weaknesses and appear vulnerable. However, such protective measures may isolate them from sources of support, including other female pastors, which may help to alleviate stressors that are unique to their experience as females in a male-dominated profession.

As in other studies (Rayburn, Richmond, & Rogers, 1986), participants in our female focus group reported that women felt a greater need to excel in the profession to overcome doubts about their competence as pastors by church leaders and congregations. Although this finding that female clergy feel the need to prove themselves is not new, female clergy in our study spoke directly to how it impacts their health. This overcompensation among female clergy is likely to increase stress, diminish boundary-setting, and reduce the time available for self-care. Thus, one might hypothesize that female clergy would evidence a greater negative health disparity to females in other professions than male clergy to males in other professions. This is an area for future research.

The intrapersonal and interpersonal challenges faced by female clergy are largely the result of perceived or real concerns that congregations and church leaders have about the competency of female pastors. Interventions from the institutional level, such as explicit support of female clergy by UMC bishops and district superintendents to congregations, may facilitate changes in these views, which would ultimately help improve

intrapersonal and interpersonal conditions for female pastors. Churches also have pastor-congregant structures in place. For example, in the UMC, each church has a Pastor-Parish Relations Committee (PPRC) that is responsible for letting pastors know what is on the minds of congregants and for feeding information from the pastor to the congregant. PPRCs could do much to support female pastors, including taking an explicitly supportive role of female pastors and encouraging female pastors to take vacation. In addition, institutional efforts to bolster the social support of female clergy may also be beneficial. The creation of a cross-denominational support network, not commonly utilized by UMC clergy, for female clergy may help waylay fears of vulnerability that may exist with denominational peers and circumvent concerns about confidentiality.

The identification of health challenges encountered by local church pastors may constitute a unique contribution to the literature, as health among this group is understudied. However, because local pastors often serve rural churches, it is impossible in the current study to disentangle the effects of local pastor status and rural living status (A. Miles, Proeschold-Bell, & Puffer, 2010). Thus, the local pastor findings reported here may be attributable to a larger group of clergy serving in rural areas.

Local church pastors reported health challenges resulting from financial limitations. Appointments for local pastors in the UMC are made depending on the needs of the conference and are more likely to be part-time with a lower salary. Increased salaries for local clergy may constitute a health intervention, but may not be a feasible solution. At a minimum, mental health benefits should be strong so that local church pastors are able to access counseling and other needed mental health services. Policy changes that encourage use of regular time off and vacation time could be instituted. To augment social support, financial support for yearly family retreats could be considered, as could the cross-denominational clergy support networks suggested for female clergy.

Young pastors are also an important group to support; between 1985 and 2008, the proportion of United Methodist Church elders under the age of 35 decreased from 15% to 5%. Much like local church pastors, young pastors reported financial barriers to health and may benefit from similar financial support. Additionally, PPRCs which are responsible for mediating relationships between the pastor and the laity of the parish, may be recruited to serve as advocates for the health of young clergy by helping to educate congregants about clergy health needs. For example, SPRCs may help congregants understand the importance of family privacy for young pastors, perhaps discouraging inquiry about plans to have children.

Young pastors' increased awareness of health issues and recognition of churches as a potential venue for health interventions present an opportunity for improving the health of congregations and other pastors. These interventions may be particularly important as the prevalence of obesity in the United States has doubled between 1980 and 2002 (Hedley et al., 2004). Some church health interventions such as creating church gardens may not only benefit congregant health but also address some of the young pastors' financial barriers to healthy food.

Clergy may be able to influence social norms and stigma surrounding mental health issues (Mattox, 2008). Because they are attuned to the health needs of congregants, young clergy may be more willing to acknowledge and accept this role. The awareness and enthusiasm for health improvement and maintenance expressed by young clergy may be particularly useful in a connectional system like that of the United Methodist Church. Young clergy may be able to serve as peer educators by helping other pastors negotiate healthy behaviors in a demanding role.

The health-protecting strategies utilized by pastors of larger churches may inform interventions that improve the health of other clergy. The ability of large-church pastors to set boundaries and take personal time shows that health improvement strategies may be successfully implemented by clergy under certain conditions.

Other clergy may benefit from encouragement to take personal time off by the institutional hierarchy as well as by their large-church peers. Perhaps pastors could be empowered to take fifth Sundays off earlier in their career, a strategy reported by clergy at large churches. Alternatively, a lesson from large-church pastors may be that a system of “on call” pastors is needed to alleviate the strain of being responsive to congregants constantly.

Our large church pastors were not only serving at a large church, but, as is common in the UMC, were also older in age. It is therefore interesting to compare their data to those of the young pastors. Overall, the large church pastors expressed greater comfort in their relationships with DSs. Perhaps this friendlier relationship is associated with a longer exposure to the norms and expectations of UMC clergy. That is, it is possible that as one ages the more one is likely to learn to cope and adapt to the intrapersonal, interpersonal, congregational, and institutional stressors of clergy life. Another possible explanation is the nature of the appointment process, which is much like any promotional system. At each level the pool of the successful decreases, common characteristics become more identifiable, and the pathways to further advancement increasingly reside with one’s peers. DSs, who have significant voice in the course of clergy careers, usually are drawn from the pastorates of larger congregations and, when their terms are completed, return to similar pulpits (Reist, Alexander, Smith, Cropsey, & The Committee on Correlation and Editorial Revision, 2008). Simply put, perhaps the upper echelons tend toward the classic revolving door model.

One might wonder whether large church pastors’ greater comfort with DSs and protecting personal time might be due to an ongoing pastor formation process. This may be true of other denominations, but in the UMC, there is no clear protocol for guiding the formation of pastors after ordination. The UMC’s *Book of Discipline* outlines a lengthy process for candidacy prior to ordination, yet has little to say about continuing education and spiritual growth after ordination (Reist et al., 2008). Nevertheless, social norms among clergy, and in particular UMC clergy with their connectional emphasis, are likely to exist. Beneficial future research may include studying conference norms around holistic health and address age through using robust research designs such as cohort studies.

Each subgroup expressed concern about the lack of “safe” venues in the conference for clergy to admit their vulnerability and seek help for a health issue other than a physical problem. The language that each group used for the stigmatized class of issues was different. Women pastors felt constrained from admitting “emotional problems.” Young pastors used the terms “mental illness” and “depression.” Large church pastors spoke of the risks of “overwork” and “burnout.” This observation may give some insight into the different perceptions these groups have of the health risks inherent in ministry work, or of the corporate culture in the UMC.

The qualitative nature of this study allows for a more thorough understanding of the facilitators of and barriers to health by clergy subgroups. However, it does not allow us to determine the degree to which these facilitators and barriers exist. The study is also limited to one Christian denomination, and further limited by the small number of participants in the female, local, young, and large church focus groups, meaning that there were a limited number of experiences for comparison across groups. Although the sample sizes for our groups were small, our findings are validated by other studies that have found similar results. For example, Birk (2001) also found that female clergy may face additional gender-related stressors at each SEF level because they work in a male-dominated vocation, and Rayburn and colleagues (1986) similarly found that females feel a greater need to excel than men.

In addition, the focus groups were not completely uniform in their demographic characteristics. For example, there was some overlap between the young and local church focus group demographics, in that two out of six local pastor participants were both local pastors and young. The local pastor and young groups each

emphasized financial strain, and it is possible that comments about financial strain in the local pastor group were made only by young local pastors. There was a particularly large percentage of large church pastors in the young and female pastor focus groups. Further analysis revealed that all of these large church pastors were associate pastors rather than head pastors. The distinction is important in that head pastors compared to associate pastors generally have more decision-making power, are later in their career, and hold more of a peer relationship with UMC conference leadership, all of which may impact their health. Therefore we are less concerned about the overlap between focus group participants of associate large church pastors than we would be about head large church pastors.

In spite of these limitations, this study deepens our understanding of occupational stressors experienced by clergy and how these stressors relate to health practices among subgroups of clergy. This study builds on a small but growing literature concerned with health promotion among these important societal leaders. Given the high rates of chronic disease among some clergy (Proeschold-Bell & LeGrand, 2010), intervention research for clergy is needed. General health behavior change principles are likely to work even better with clergy if their multi-level ecological conditions are taken into account. Future research on other subgroups of clergy, such as clergy couples and African American and Latino clergy, is needed to develop further health promotion among all clergy. We hope that a healthy pastorate will benefit clergy and congregation members alike.

**Table 1. Demographic overlap between focus group participants**

Designated focus group category	Size of focus group	N of women	N of young pastors	N of local pastors	N of large church pastors by type	
					Associate pastors	Head pastors
Women pastors	6	6	0	2	3	0
Young pastors	7	3	7	0	3	0
Local pastors	6	3	2	6	1	0
Large church pastors	7	3	0	1	4	3

## Author's Note

Sara LeGrand, Center for Health Policy and Inequalities Research, Duke University; Rae Jean Proeschold-Bell, Center for Health Policy and Inequalities Research, Duke University; John James, Duke Divinity School, Duke University; Amanda Wallace, Duke Divinity School, Duke University.

This study was funded by a grant from the Rural Church Program Area of The Duke Endowment. The authors gratefully acknowledge the insightful comments of The Reverend H. Edgar Moore, Ph.D., Matthew Toth, M.S.W., Rachel Blouin, M.P.H., Monica Rivers, Ph.D, and David Toole, Ph.D. We thank the participating pastors for their honesty and insights.

## References

- Birk, J. (2001). Religious Occupations and Stress Questionnaire (ROS): Instrument development. *Counseling and Values, 45*(2), 136.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.
- Carroll, J. W. (2006). *God's potters: Pastoral leadership and the shaping of congregations*. Grand Rapids, MI: William B. Eerdmans Pub.
- Charmaz, K. (2001). Grounded theory. In R. M. Emerson (Ed.), *Contemporary field research* (pp. 335-352). Long Grove, IL: Waveland Press.
- Creswell, J. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications, Inc.
- Halaas, G. (2002). Ministerial health and wellness, 2002. Chicago, IL: The Evangelical Lutheran Church in America.
- Hedley, A. A., Ogden, C. L., Johnson, C. L., Carroll, M. D., Curtin, L. R., & Flegal, K. M. (2004). Prevalence of overweight and obesity among US children, adolescents, and adults, 1999-2002. *Journal of the American Medical Association, 291*(23), 2847-2850.
- Kelly, J. (2006). *On becoming ecological: An expedition into community psychology*. New York, NY: Oxford University Press.
- King, H., & Bailar, J. C., III. (1969). The health of the clergy: A review of demographic literature. *Demography, 6*(1), 27-43.
- Kuhne, G. W., & Donaldson, J. F. (1995). Balancing ministry and management: An exploratory study of pastoral work activities. *Review of Religious Research, 37*(2), 147-163.
- Lee, C., & Iverson-Gilbert, J. (2003). Demand, support, and perception in family-related stress among protestant clergy. *Family Relations, 52*(3), 249-257.
- Lewin, K., & Cartwright, D. (1951). *Field theory in social science*. New York, NY: Harper.
- Mattox, R. (2008). Treatment: "Just what the preacher ordered". *Psychiatric Services, 59*(4), 349.
- McDuff, E., & Mueller, C. (1999). Social support and compensating differentials: Gender differences in two protestant denominations. *Review of Religious Research, 40*(4), 307-330.



- McLeroy, K., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, *15*(4), 351-377.
- Meek, K. R., McMinn, M. R., Brower, C. M., Burnett, T. D., McRay, B. W., Ramey, M. L., . . . Villa, D. D. (2003). Maintaining personal resiliency: Lessons learned from evangelical protestant clergy. *Journal of Psychology and Theology*, *31*(4), 339-347.
- Miles, A., Proeschold-Bell, R. J., & Puffer, E. (2010). Explaining rural/non-rural disparities in physical health-related quality of life: a study of Untied Methodist clergy in North Carolina. *Quality of Life Research*, 1-9. doi: 10.1007/s11136-010-9817-z
- Miles, M., & Huberman, M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Morris, M., & Blanton, P. (1994). The influence of work-related stressors on clergy husbands and their wives. *Family Relations*, *43*, 189-195.
- Muhr, T., & Friese, S. (2004). *User's Manual for ATLAS.ti 5.0* (2nd ed.). Berlin: Scientific Software Development.
- Proeschold-Bell, R. J., LeGrand, S., James, J., Wallace, A., Adams, C., & Toole, D. (2009). A theoretical model of the holistic health of United Methodist clergy. *Journal of Religion and Health*, 1-21. doi: 10.1007/s10943-009-9250-1
- Proeschold-Bell, R. J., & LeGrand, S. H. (2010). High rates of obesity and chronic disease among United Methodist clergy. *Obesity*, *18*, 1867-1870. doi: 10.1038/oby.2010.102
- Rayburn, C. A., Richmond, L. J., & Rogers, L. (1986). Men, women, and religion: Stress within leadership roles. *Journal of Clinical Psychology*, *42*(3), 540-546.
- Reist, L., Alexander, N., Smith, J., Cropsey, M., & The Committee on Correlation and Editorial Revision (Eds.). (2008). *The Book of Discipline of the United Methodist Church*. Nashville, TN: The United Methodist Publishing House.
- Rowatt, G. (2001). Stress and satisfaction in ministry families. *Review and Expositor*, *98*, 523-542.
- Strauss, A., & Corbin, J. (1990). *Basics of Qualitative Research: Ground Theory Procedures and Techniques*. Thousand Oaks, CA: Sage Publications, Inc.
- Trickett, E. (2009). Multilevel community-based culturally situated interventions and community impact: An ecological perspective. *American Journal of Community Psychology*, *43*(3), 257-266.