

A Theoretical Model of the Holistic Health of United Methodist Clergy

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Abstract

Culturally competent health interventions require an understanding of the population's beliefs and the pressures they experience. Research to date on the health-related beliefs and experiences of clergy lacks a comprehensive data-driven model of clergy health. Eleven focus groups with 59 United Methodist Church (UMC) pastors and 29 UMC District Superintendents were conducted in 2008. Participants discussed their conceptualization of health and barriers to, and facilitators of, health promotion. Audiotape transcriptions were coded by two people each and analyzed using grounded theory methodology. A model of health for UMC clergy is proposed that categorizes 42 moderators of health into each of five levels drawn from the Socioecological Framework: Intrapersonal, Interpersonal, Congregational, United Methodist Institutional, and Civic Community. Clergy health is mediated by stress and self-care and coping practices. Implications for future research and clergy health interventions are discussed.

The Duke Clergy Health Initiative is a \$12 million, seven-year effort to study and improve the health and well-being of United Methodist clergy in North Carolina.

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Clergy Health

The health of clergy is a compelling, though somewhat neglected, topic. Clergy, in their humanity, are subject to the health sciences research on exercise, diet, and stress that holds true for everyone. However, the respected position clergy hold may lead both congregants and health researchers alike to assume that clergy live a life characterized not only by commendable spiritual disciplines, but also by wise eating, exercise, and stress management habits. For example, it is tempting to think that the restraint clergy possess in other areas of their lives will naturally carry over to resisting things like substance use and unhealthy food. This temptation is not entirely unwarranted. Research has shown lower mortality rates for clergy compared to their non-clergy peers due to less syphilis, accidents, and suicide (King & Bailar, 1969). However, this same research notes that mortality data from circa 1950 suggest that clergy in Great Britain and the United States had higher mortality due to coronary disease than their non-clergy peers (King & Bailar, 1969). Since 1950, there have been frightening increases in overweight and obesity in the United States (Flegal, Carroll, Ogden, & Johnson, 2002), and clergy are not likely to be immune from this trend. Although overall mortality rates are much lower for all clergy combined than their peers (Flannelly, Weaver, Larons, & Koenig, 2002; King & Bailar, 1969), mortality data that is specific to both disease and religious denomination suggest that it is premature to infer that all clergy groups have improved mortality rates. For example, an examination of 12 clergy health studies reported that United Lutheran clergy had higher mortality due to hypertension associated with heart disease than clergy from other churches, whereas Presbyterian and Episcopalian clergy had higher mortality due to diabetes than clergy from other churches (Flannelly et al., 2002; King & Bailar, 1969).

There is also a growing literature on stress and burnout among clergy. Pastors have reported difficulties with stress, feelings of inadequacy, and frustration meeting ministry goals (Ellison & Mattila, 1983), and data indicate that there is an increase in burnout and dissatisfaction with ministry among clergy families (Rowatt, 2001). Stress among clergy families has received theoretical attention, most notably from Lee and Iverson-Gilbert (2003), who used an ecological approach to understanding the clergy family as embedded in the multilevel social context of family, congregation, denomination, and community. They contend that most of the literature on clergy families has attempted to identify the stressors of pastoral ministry, to the neglect of coping resources and perceptions. A notable exception is a set of studies that found that clergy primarily rely on intrapersonal coping strategies such as praying, trusting God, and taking time off (McMinn et al., 2005).

In terms of depression and anxiety among clergy, few studies exist. Self-report data from a large sample of male parochial clergy in the Church of England indicated that 30% of pastors had experienced depression, and 21% acute anxiety, since ordination (Turton, 2003, as reported in Turton & Francis, 2007). In another study, senior pastors with no staff who read *Leadership* magazine were asked how much “depression” or “anxiety” they experienced on a five-point scale (Ellison & Mattila, 1983). The mean for depression was toward the high end at 3.35, and anxiety was 3.90. Another study found that ministers had significantly higher scores on the depression scale of the MMPI if they had low congruence with ministry (based on the career-fit measure, the Strong Interest Inventory Minister Scale) (Celeste, Walsh, & Raote, 1995).

The spiritual resources of clergy, as measured by a Spiritual Well-being Scale, are high (Darling, Hill, & McWey, 2004). Out of a range of 20-120, the mean for clergy was 106 (SD 14). The same measure found that spiritual well-being was significantly lower for clergy spouses (101, SD 17), although still high. For both clergy and their spouses, spiritual well-being mediated the relationship between stress and compassion fatigue. Higher frequency of prayer among pastors has also been found to relate to higher self-reported mental health and general health (Meisenhelder & Chandler, 2001).

Together, these studies suggest that clergy are not immune to depression and anxiety, even though their strong spiritual resources provide some protection. Congregants, often rightly, perceive the strong spiritual resources that clergy possess, but at the same time they may put clergy on a pedestal (Blackbird & Wright, 1985; Rayburn, Richmond, & Rogers, 1986). In this elevated role, clergy may be reluctant to admit role strain and may end up with more stress and isolation than congregants. It would be ironic if public health researchers similarly neglected the health needs of clergy.

In light of these red flags for clergy—these early warning signs of stress, diabetes, and coronary disease—it is interesting to consider how to tailor public health interventions to clergy. Culturally competent interventions take into account a population's belief systems and the specific pressures they experience (Dumas, Rollock, Prinz, Hops, & Blechman, 1999; Gibson et al., 2004). Initial research on antecedents of clergy health has focused on sources of stress experienced by clergy. For example, Rowatt (2001) conducted a qualitative survey of both male and female clergy and their spouses and discovered the following four categories of stressors: vocational stressors (inadequate pay, low work satisfaction, unrealistic time demands, relocation); intrapersonal stressors (emotional exhaustion, burnout, low personal satisfaction, sense of personal failure); family stressors (low family satisfaction, lack of family time, lack of privacy); and social stressors (high expectations regarding behavior, criticism, intrusiveness, lack of social support). Lee and Iverson-Gilbert (2003) conceptualized the antecedents of pastoral stress as occurring in four primary categories: personal criticism, boundary ambiguity, presumptive expectations, and family criticism. They view these causes of stress as leading to lower pastor well-being and greater pastor burnout. In addition, based on a review of the literature on clergy stress since the early 1950s, Morris and Blanton (1994) cited the following five stressors as the most salient for clergy: mobility, financial compensation, social support, time demands, and intrusions on family boundaries.

As the number of identified clergy health antecedents grows, a unifying model becomes increasingly useful, both to aid the understanding of clergy health and to inform interventions to sustain and improve it.

The United Methodist Church Structure

In building a model of clergy health, it is important not to assume that clergy of every religion and denomination experience the same barriers to, and facilitators of, health. Because of important systemic and belief differences between religions and denominations, research generalizing across all of them is likely to lose important substance. Our research focuses on clergy in the United Methodist Church (UMC), which has its own unique structure. Unlike most Protestant denominations, the United Methodist Church operates under an itinerant system. Rather than being hired or “called” by a local church, clergy are formally employed by the regional body, known as the Annual Conference. Local congregations receive their pastors via appointment by the Bishop of the Annual Conference. It is generally agreed that longer pastoral tenures are ideal, and some UMC clergy appointments last ten years or longer, but tenures of three to five years are common. Executive and supervisory positions within each conference are also governed by appointment, and future supervisors may be elevated from the “rank and file” unexpectedly.

Another important aspect of the UMC is that there are several ordination categories among clergy. Most UMC pastors are Elders in Full Connection, who have earned a post-graduate seminary degree (usually a Master of Divinity), have completed the denomination's and Annual Conference's examination process for ordination, and have served a probationary period. Local Pastors are a sizable and growing category of ministers who are licensed rather than ordained and who usually lack seminary training. Elders are guaranteed an appointment each year, whereas local pastors may not receive an appointment every year, depending on the needs of the conference. Some clergy are paid on a part-time basis, depending on the size of the congregation(s) they serve.

Our sample is drawn from the North Carolina and Western North Carolina Annual Conferences. These two conferences represent about 2,100 congregations and include nearly every UMC congregation in North Carolina. Over 60% of United Methodist churches in North Carolina are considered rural, and the median church size, measured by average weekly worship attendance, is about 50 persons. The median age of pastors serving congregations is 53, with 25% being female. In terms of race, identification is 90% White, 6% African-American, 1% Hispanic, 1% Asian, and 1% Native American. Calculating clergy income is complicated by the fact that many pastors receive housing allowances or the use of church-owned housing. However, in terms of base salary, and counting only full-time parish clergy, the median salary in these two conferences is about \$45,000.

The Socioecological Framework

The primary goal of this study was to develop a model of the health of United Methodist clergy. We chose to draw upon the Socioecological Framework (SEF) to ground our model development. The SEF consists of five levels that influence health (McLeroy, Bibeau, Steckler, & Glanz, 1988). The Intrapersonal level consists of an individual's beliefs and characteristics. The Interpersonal level consists of relationships between the individual and key persons and small social networks, such as one's spouse, family, and close friends. The Community level consists of shared identities, experiences, and resources for health. The Institutional level consists of rules, regulations, policies, and ethos that may promote or endanger health. Finally, the Policy level consists of policies, environments, and structures that impact health. We chose the SEF rather than other health theories, such as the Health Belief Model (Rosenstock, Strecher, & Becker, 1988), because the breadth and depth of the SEF allow it to be tailored to particular socio-cultural contexts and situations. In addition, the SEF is useful for understanding intervention design. It posits that individual behavior and social influences are inter-related (Stokols, 2000), and that each level of the SEF is capable of impacting other SEF levels.

Methods

Focus Groups

We chose to collect data using focus groups in order to allow clergy to reflect on the similarities and differences of their own experiences in relation to others'. We held an initial set of four focus groups, consisting of two focus groups from each North Carolina UMC conference. We drew these 33 initial participants from the published conference Journals. We selected for invitation based on proximity to the meeting sites (two being urban and two rural), and invited via e-mail or phone. We made an effort to invite pastors who were diverse in age, gender, and race. Questions in the focus group guide were unstructured to semi-structured. The questions focused on how participants conceptualize

health; what they perceive as facilitating good health and what they see as barriers to it; and the perceived relationship between the congregation and the health of the pastor. Focus groups lasted 60-90 minutes. The study was approved by the Duke University Institutional Review Board.

We selected a grounded theory approach to data collection and analysis because our primary goal was not only to understand the phenomenon of clergy health, but also to pose a theoretical model of how clergy engage in their environment and systems as related to their health (Creswell, 1998). Congruent with the grounded theory approach, we began the analysis process while collecting the data (Strauss & Corbin, 1990), and the research team met after each focus group for discussion and theme generation. The interview guide was a dynamic document, and new probes and questions were added as themes emerged. We developed an initial model after the first four focus groups. At this point, we determined that the data suggested that specific kinds of clergy likely had different health-related experiences and perceptions. We then engaged in theoretical sampling (Creswell, 1998), that is, selecting participants who might best contribute to theory. We conducted four additional focus groups: 1) female pastors (n=6); 2) pastors of large churches (ranging in membership size from 600 to 4,000 members) (n=7); 3) local pastors (n=6); and 4) pastors under the age of 35 (n=7). Questions on the relationship between their demographic group and health were added to the focus group guides. After conducting these additional groups, themes raised by the participants had reached the point of redundancy, also known as the point of saturation (Glaser & Strauss, 1967).

However, because so many themes raised by participants pertained to the UMC itinerant ministry system within which participants serve, we decided to conduct three additional focus groups with District Superintendents (DSs) (n=29). DSs report directly to the bishop, with each conference being led by a single bishop. DSs and their Bishop constitute an Annual Conference's cabinet, which appoints pastors to churches. DSs also supervise pastors. Most DSs have previously served as pastor. Between the two conferences, there are 27 DSs in North Carolina. Incoming, current, and outgoing DSs convened for a day for other purposes and allowed us to conduct focus groups.

All focus groups, which were conducted between January and May 2008, were audiotaped and transcribed. After each focus group, we asked participants to complete a brief demographic survey (see Table 1).

Data analysis began immediately after the start of data collection and was an iterative process of collecting and reviewing data, asking questions of participants and the data, reviewing the data again, and returning to the questions again. We sought regularities and patterns in the data and derived coding categories directly from the data rather than from pre-existing hypotheses (Charmaz, 2001). However, the interpretation of data inevitably is an interaction between those observing the data and the research participants (Charmaz, 2001), and we recognized that our own religious traditions and disciplinary backgrounds would affect data analysis. To minimize bias in data analysis, nearly all analysis occurred with a group of four of this paper's authors, two of whom are committed Christians and two of whom have minimal religious tradition. These four researchers hail from the disciplines of psychology, divinity, literature, and behavioral health. We promoted confirmability (Miles & Huberman, 1994) by having two researchers code all transcripts using Atlas.ti version 5.2 (Muhr & Friese, 2004). We resolved discrepancies through discussion until consensus was reached. To understand the data, we examined units of data from each code for integrated schema. This process is also known as pattern coding (Miles & Huberman, 1994). We further examined themes for higher-order domains to help organize the data. Additionally, our theory-building included examining themes and concepts in relation to each other, while seeking out participant conceptualizations of causality and patterns of health-related behavior.

Table 1: Demographic summary of focus groups*n*=87

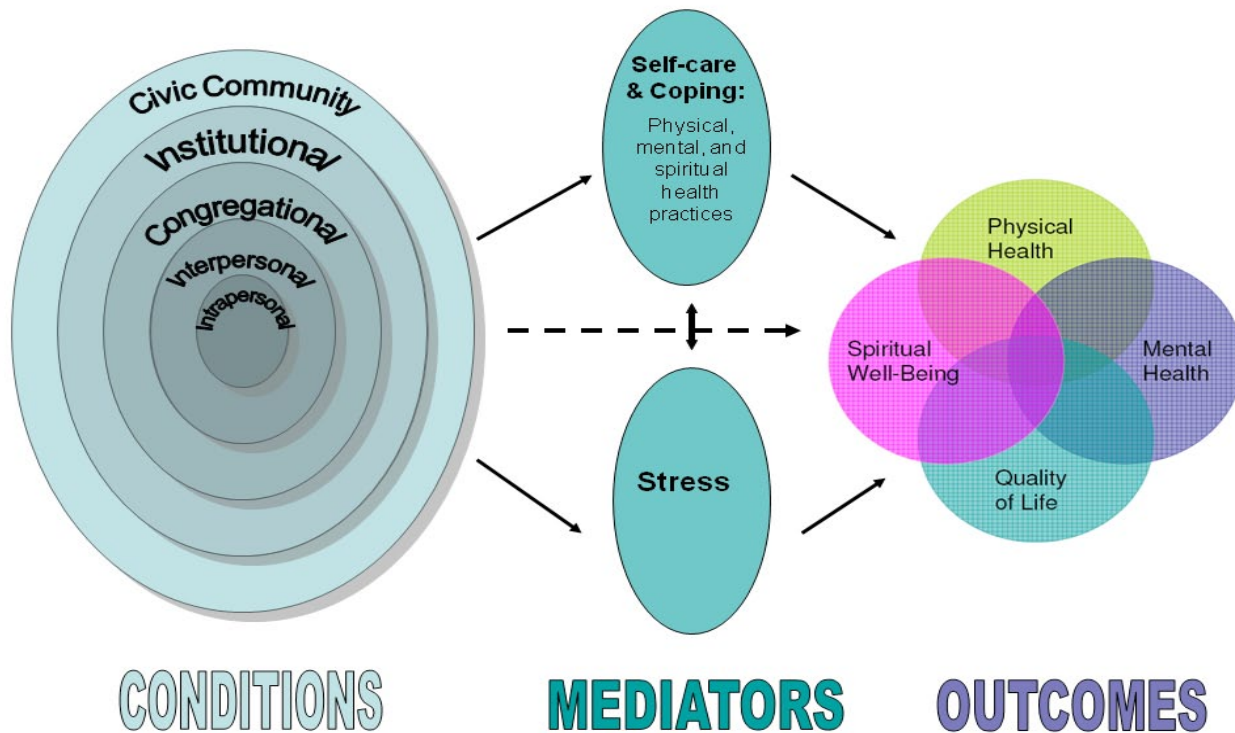
Characteristic	
Male	61%
Female	39%
Age	
21-30 years	7%
31-40 years	10%
41-50 years	22%
51-60 years	40%
61-70 years	18%
71+ years	2%
Race	
White	91%
African American/Black	6%
Native American	2%
Ordination status	
Elder	64%
Local pastor	23%
Deacon	4%
Other (e.g., Probationer)	10%
Outside paid employment	10%
Current appointment	
District superintendent	34%
Solo pastor, single church	27%
Solo pastor, multiple churches	13%
Associate pastor	15%
Head of staff	10%
Other (e.g., extension ministry)	2%
Years in ministry	Mean=17.9 yrs (range, 1-43)

Results

Theoretical Model Overview

The theoretical model arising from the data is depicted in Figure 1. In this model, conditions for each of five socioecological levels are defined and seen as potentially leading directly to clergy health, or indirectly to clergy health via two mediators. The first mediator is Self-care and Coping. Self-care is defined as behaviors and practices intended to promote physical health, mental/emotional health, or spiritual well-being, or a combination of all three. Because many self-care practices may promote more than one kind of health, we found it undesirable to separate self-care practices by targeted health outcome. For example, observing the Sabbath--keeping inviolate a day apart from the usual tasks

Fig. 1: Theoretical model of United Methodist clergy health



of ministry--may benefit mental and physical health, as well as spiritual well-being. We also combined coping with self-care, because many of the self-care practices intentionally or unintentionally help clergy cope with the conditions identified in the socioecological levels. For example, individuals may exercise in the interest of physical health, but also use it as a strategy to cope with stress (Rostad & Long, 1996). In Figure 1, this impact of self-care and coping on stress is depicted with an arrow from Self-care and Coping to Stress. The second mediator, Stress, is conceptualized as being affected by many of the conditions identified in the socioecological levels. Stress, in turn, impacts Self-care and Coping, as well as health and well-being. In this model, we define our final health outcome holistically in order to indicate that health is not merely the absence of problems but is, rather, the presence of multiple life satisfactions. The outcome thus includes not only physical and mental health and spiritual well-being, but also the overall quality of life.

Based on the data, we altered slightly the ecological levels usually identified in Socioecological Framework theory. Participants emphasized the contexts of their congregations and the United Methodist structure in which they serve. They also addressed to a small degree the impact that their surrounding town, or civic community, had on their health. In contrast, even though public policies such as seat belt laws surely have some impact on clergy health, participants did not mention such policies.

Within each socioecological level, we attempted to identify conditions that are less amenable to change and to list them last. We erred on the side of putting fewer conditions into this less-amenable-to-change category, in order to maximize intervention ideas, even if certain conditions would be quite hard to change.

Socioecological Conditions

We derived 42 conditions impacting clergy health from the data. We assigned these conditions to a socioecological level based on the context in which participants described the condition. These conditions are depicted in Table 2. Although we have data to support each condition, it would be tedious and long to cover each condition. Here, we have chosen to provide supporting data for the conditions to which participants gave the most importance, based on the number of participants who discussed the condition and the amount of time, detail, and affect devoted to the condition. The conditions that participants indicated as having the greatest effect on their health are: ability to set boundaries, perception that the pastor is available 24 hours/day, church health and functioning, itinerancy, and financial strain.

Table 2: Conditions related to the health of United Methodist clergy by socioecological framework level

Intrapersonal	Interpersonal	Congregational	Institutional	Civic community
Putting everyone else's needs before own	Family support	Congregational norms about food	Expectations from DSs, bishops, and peers	
Unrealistically high expectations for self	Support from other pastors	Congregation's understanding of pastor's roles	Relationships with congregants affect DS perception of pastor	
Financial strain	Support from DS and bishop	Laity's expectations of pastors as paid professionals	Perception that overwork is rewarded by bishops and DSs	
Extent of physical health knowledge	Support from friends	Laity's support for pastor self-care practices	Compensation structure	
Ability to set boundaries to protect personal time	Support/criticism from congregants	Congregation/SPRC perception of pastor's 24-hour availability	Existence of unhealthy churches	
Ability to handle conflict	Living up to priestly role	Church health and functioning	Lack of support when charged with an unhealthy church	
			DS communication to SPRCs and congregations about pastors' self-care	
			Perception that mental health care is stigmatized by DSs and bishops	
			Itinerancy	
			Multiple charges	
<i>Less amenable to change</i>				
Marital/family status	Family needs	Complexity of pastor's work	Church size	Rural / urban setting
Gender		Lack of privacy	Ordination status	Norms about food and exercise
Age				Resources available (health, public, social)
Education				Economic conditions
Ethnicity				

"Institutional" refers to the United Methodist system

"DS": District superintendent

Boundary setting and constant availability

Participants reported being overwhelmed by pastoral needs from congregants and community members. They reported that they struggled with setting boundaries in order to protect their time for self-care, and indicated that failure to set these boundaries affected self-care practices, such as exercise and family time.

I was right where [he] was, my phone rang 24/7. ... Ten o'clock at night or six o'clock at night and the phone rings. And I finally said after five o'clock I will not take it. 'Can this wait? Can you call me tomorrow when I'm in the office?' 'Yes.' 'Then do it.' And after a while it got to the point that they finally understood and finally the phone calls, amazingly, the phone calls just stopped. ... And I really didn't do it rudely, but it just got to the point that I had to tell them that I had a family. That was one of their requirements is they wanted a pastor with a family. They had one. And my requirement was that I have time with that family. For our health we had to have that time.

Clergy shared that they faced several barriers to protecting personal time, including their own servant orientation and the expectation by congregants that they be constantly available:

I think some of it's the moral imperative between the secular world and the church world. In the church, if I block off my schedule that I'm going to exercise or I'm going to do this or this for me, even down to diet, when you're eating in people's homes and that sort of thing ... When you block this off, it's almost like you're being selfish and that's bad. 'We want our pastor to be available.' Whereas in the secular world, there's more of an understanding, or it appears to be, that you're looking after your own health.

I don't know whether people ever realize but really a full-time pastor is really like a medical doctor. You are really on call 24 hours because there's just a crisis in the hospital at four o'clock in the morning families want somebody to talk to. They will call you here and get you up out of bed.

Several participants noted that the expectation of constant availability made taking vacations particularly difficult. Pastors reported that their Staff-Parish Relations Committees (a UMC's local equivalent of a personnel committee) sometimes dissuaded pastors from taking vacations when several congregants were sick. Pastors were expected to be there to attend to the sick and to be available in the event of a death.

My Chair of Church of Council took me to task last Church Council because I had a vacation planned the first week in March and there's several people sick and he didn't think I ought to go. Because somebody might get sick or die and then I'll be in Florida and not [be] easily accessed.

Thus, it is this Congregational-level set of expectations on pastors that, in part, make it difficult for pastors to enact Intrapersonal-level boundary setting. However, other Intrapersonal conditions including pastors' tendency to put everyone else's needs before their own and to have unrealistically high expectations for themselves also impede their boundary-setting abilities.

Church health and functioning

Participants reported that unhealthy church dynamics had a large effect on their health. Specifically, participants noted three situations that affected that their sleep and anxiety levels. One situation is that in which a number of congregants oppose even small changes suggested by the pastor. One participant described it this way:

The people have this, 'I'm right. Everybody else is wrong,' attitude that works the hardest on the pastors. Because everything that they don't like they turn into an issue because they're right and everybody else is wrong. ... And it just destroys the 'me.' You can't get beyond it; you can't reason with it. It would kill any pastor to be in that situation.

A second situation is that in which the church has two sets of members who polarize issues along group lines. For example:

What you have is that, 'My great-great-grandmother got in a family feud with Mary's great-great-grandmother many, many years ago, even before I was born, but it was instilled in me by my mother not to associate with this family. And so when I see these people and these people want to do something, then it's a tradition on this side of the church that my family's not going to support it.

A third situation is that in which one or more congregants use intimidation or abusive tactics to oppose the pastor.

They spread rumors in the community ... stuff out in the community that are meant to hurt a person. I've been heckled when I preach, when I've been praying. I've had people get up and stomp out and slam doors. Just like children temper tantrums is what it gets down to because they can't get their way and overrun everybody else. And it just gets very difficult to deal with. People calling you at all times of the day or night saying really nasty things to you, saying nasty things to your children that don't want to ever go back to church again. Just tearing your family apart.

Pastors reported that each of these situations caused them great stress and took a toll on their health. In contrast, participants also noted that support from churches could benefit their health: "It does depend upon whether the parish you're serving is healthy or not. There are those that have healthy practices, have a tradition of being supportive of the pastor and so forth."

Whereas the health of the church occurs at the Congregational level, the UMC response to unhealthy churches occurs at the Institutional level. The DS participants indicated that improving the health of churches was difficult and that there were few resources they could devote to the task. They reported finding themselves faced with the unpleasant task of deciding which pastors to assign to unhealthy churches.

And I don't know how you do it, but I think that we talk a lot about ineffective clergy and I think that we need to also give some thought to what do you do about ineffective churches or toxic churches. I mean, and it seems like that what we end up doing is we put some of these toxic, troubled pastors with toxic, troubled churches and thinking that they deserved each other or that they'll heal each other or whatever. I guess it's that old thing that two negatives make a positive. [laughter] But it hasn't worked yet.

Participants also expressed frustration at the lack of support they sometimes perceived receiving when being appointed to an unhealthy church.

Because especially when you're in a situation where you are very aware of all this antithesis of good health going on around you and it sucks you into it. And then when your system, the church, does not even acknowledge that that's really the state of your circumstances, you feel like you're in it all by yourself and that there's no end to it.

Itinerancy

Although we did not ask directly about the effects of the UMC itinerant system on pastor health, a theme of itinerancy negatively affecting health emerged. Receiving a new church appointment is fairly frequent in the NC UMC conferences, with about 25% of pastors moving in any given year. Pastors may have several months' notice before taking a new appointment, or they may receive only a few weeks' notice. One DS reported that, because moving is commonplace in the UMC, it is only now becoming widely recognized that moving is stressful.

And I think that we are beginning to name that but there is still this kind of, 'Everybody does it.' You understand what I'm saying? It's like, 'Well, big deal. Everybody, we all move.' But we're beginning to name the stress that this puts on people. But I'm not sure that we have anything in place that really acknowledges that to help people deal with it when they're moving. Except we say, 'Now take care of yourself when you move.' [laughter]

Pastors were clear that moving has negative effects, even in cases when they welcomed the new appointment. They indicated that itinerancy disrupts regular sources of medical care.

I think that is also problematic in our profession when you move around. ... In my own case of 30 years of ministry I've had two physicians that I really had that relationship with. And it does make a difference. I just think you're more apt to go and to really say what's going on if you feel comfortable with that person.

Woven into the complexity of itinerancy were themes of disruption of exercise routines and gym memberships, and also social networks. Obviously, moving away means less in-person contact with a friend. However, because pastors move frequently, the UMC system asks pastors not to return to their former congregation in order to allow the newly appointed pastor to establish him- or herself. Knowing this requirement may discourage pastors from developing deep friendships in the first place.

But I think that's something that ought to change because we try to build relationships and friendships ... I went ahead and built mine. I don't go back or anything, but I stay in touch with folks. But we know that if we go through town we have to stop and ask a pastor's permission. ... And that's why we don't build those friendships. Because somebody says we can't have them.

Thus, pastors reported that moving to a new appointment often means changing their social support circles and relinquishing friendships. Pastors reported that leaving behind a church and the corresponding friendships is "kind of like grief." One DS suggested that the lack of a formal grieving process is unhealthy for pastors.

Explore the moving process. Everything we know about grief, stress, loss, we throw out the window - no time to disengage, no time to engage. We expect everybody to have cried their tears by 12 o'clock and be ready for Sunday service. That alone would open up ways to cultivate better health practices.

Participants also reported that the itinerant system forces pastors to re-establish their authority as pastor; creates financial strain; and takes a great toll on spouses and children. Pastors acknowledged that their calling positioned them as servants in the UMC and that they accepted the difficulties accompanying itinerancy as their choice: "We enter into ministry and it's an itinerancy system. We recognize that." They expressed greater concern about the impact of these moves on their spouses and children than on themselves.

[Changing churches] was really kind of earth shattering to [our kids]. Because they don't have pastors. They can't come to me and say, 'I'm really struggling with whatever.' Because they're not necessarily going to feel comfortable doing that. And they do, but it's, 'That's Mama.'

The spouse gives up a job they love. And then we go to a new place and all of a sudden her friends are none close by. ... There are huge stresses in that move for the spouse that just aren't addressed.

This itinerant system affects the Interpersonal level by creating new family needs in each move and disrupting support from friends and individual congregants. Itinerancy can also send pastors to areas with few health resources (Civic Community level). The fear of being assigned to an unhealthy church also leads pastors to attempt to stay in favor with their DS. These attempts may result in not admitting when they need help, which may exact a toll on health.

Financial strain and the UMC compensation structure

Participants also emphasized the UMC compensation structure and its effect on health. Just as the Annual Conference determines where pastors will serve, the conference effectively determines what their salary will be. Although local churches set their pastor's salaries, Bishops and cabinets usually appoint pastors within salary scales. At the lower end of the salary scale (e.g., \$34,000), resources such as healthy food and exercise facilities may be unaffordable, especially for those pastors raising a family.

I know people whose meals are never quite like my five course meal because they just can't afford it yet.... I can afford basically foods that are good for me now but I could not at another point in my life.

Another obstacle, I think, for me, is realistically the financial one. I had a membership to the Y and then my financial situation became really strained and I had to cut out some things and that was the thing to go.

Often [those] who need the rest the most can't afford - not jobwise but just financially - to go to the retreat center ..., which can be a very healing, restoring thing.

The salary structure in each Annual Conference is public knowledge, and there are wide disparities between what early-career pastors and late-career pastors earn, which can create stress and resentment.

[T]he salary disparity among pastors... it's just ridiculous that somebody can get a free membership to a country club and \$120,000 salary and then the person who is probably putting in more hours in a rural church gets \$30,000 a year. That's sinful.

Because the number of higher-salary churches is limited, the UMC compensation structure also puts pastors in competition with each other for the higher-paying appointments. DSs and bishops decide which pastors to place in these appointments. The consequence is that pastors do not want to raise any red flags, such as engaging in mental health services, that might mitigate against their appointment to a higher-salary church.

Mediators

Self-care and Coping

In order for clergy to achieve favorable health outcomes, they must be able to employ strategies for self-care and utilize positive coping mechanisms. The conditions identified in the model may help or hinder self-care and coping efforts; therefore, self-care and coping are considered to be mediators between conditions and health outcomes.

For example, participants indicated that the level of the laity's support for pastor self-care practices (Congregational level) has an important effect on clergy self-care and coping. Clergy who are supported by their congregations reported being more likely to engage in self-care practices. In contrast, the tendency of pastors to put everyone else's needs before their own (Intrapersonal level) may result in challenges with self-care and coping.

Any human being, it's easy to get out of balance. And the issues surrounding ministry - being selfless, taking care of other people. You're supposed to put the oxygen mask on your face first but that often doesn't happen with clergy health issues, emotional and spiritual and physical.

Another example of the relationship between conditions and self-care and coping is given by the following DS who acknowledges the lack of encouragement for clergy self-care activities.

And those are the things that we hold people accountable to and we're firm about but we're not as diligent about the person who's not taking care of themselves. I mean, we ask the question, 'What are you doing to take care of yourself?' And we may say, 'Well, you need to do more. You need to do a better job in taking care of yourself.' But I don't know that we really hold people accountable, that we follow through, that we somehow relay to them that we truly value and think it's important for them to be healthy and whole.

Participants often made the link between self-care and coping and health outcomes. For example, they recognized exercise for its importance in maintaining physical and emotional health: "I think exercise, it just burns off the stress. It helps you physically, of course, but it's just essential I think."

Several participants discussed the importance of taking a Sabbath or a spiritual retreat. Although this was important for spiritual well-being, participants also recognized the impact on emotional and physical health.

We think sometimes, 'Okay, well, I'm right there with God because I'm preaching and I'm reading the Bible and I'm doing that stuff all the time.' ... Because it's so easy for us to get caught up in the busyness of being the pastor that we don't take time to feed ourselves spiritually. And, you know, it's embarrassing to say, but I think if we were all honest we'd say that sometimes there's days that we don't do our devotion, we don't sit there and have that time alone with God and we think, 'Well, I was doing sermon prep. Doesn't that count?' No, it doesn't. ... We need to understand that being quiet and being still in the presence of God is key to who we are. And I know for me, the further I get away from that center, the worse I feel spiritually, physically, all of that.

One of the things that I was going to offer is the need for Sabbath rest. In other words, a day off. A lot of clergy don't even take a day off. And so that begins to wear and tear physically, mentally, spiritually and every other way.

The way an individual copes with pastoral stress can positively or negatively impact health. Participants frequently mentioned religious coping, noting its effect on emotional health.

I think, as you get older and you go through life's experiences, you start to realize what's important and what's not. And I found myself doing a lot of work that wasn't

that important to anybody but me because I had to be busy. And now that I'm not doing work to be busy, nobody cares. So, I'm the only one that cared to begin with [laughter]. So, I was working myself to death for nothing! But, there was a time about two years ago that I think I came close to having my breakdown, my burn-out moment. And whenever I talked to someone about it and they said, "Well, you can either go to a part-time church,"--I'm a full-time now--"Or change churches." And I thought, "That's not the solution I wanted." I just need ... some of this burden taken off. And then I figured out that I had to figure out for myself. ... And I think, really, just putting my trust in the Lord and really believing that it's his ministry, not mine.

Stress

Several of the identified conditions across the SEF levels may be sources of stress among clergy. For example, financial strain, criticism from congregants, work complexity, itinerancy, and living in a resource-poor area all may contribute to the level of stress experienced by clergy. Research has shown a clear relationship between an individual's stress level and health outcomes. In our data, stress arose as a mediator between conditions and health. Some pastors acknowledged the relationship between pastoral stress and physical health.

I was remembering being at a seminar at Methodist College a number of years ago on time management. And ran us through this score thing and every different life stress event got a certain number of points. [He] said, anybody with over 200 points in a year is a candidate for a heart attack. And I think a full third of the people in the room had over 400 points. And the leader was just stunned and just didn't really know where to go with the whole teaching at that point. But that, it's just not the same as - he was coming out of a regular old business model.

Others highlighted the association between stress and mental health.

I think, too, ministry is stressful for everybody, just the nature of any helping profession, I think that it's across the board. But there is also a pattern of toxicity in some congregations [murmurs of agreement from group]. That it doesn't matter how healthy a pastor you send in you're going to really have a hard time staying healthy because of personal dynamics, ego, territory, unchristian attitudes, that manifest themselves over a period of time in congregations...There's no question to me that that really impacts the mental health of ministers. And sometimes we know that going into. Sometimes you get surprised and find it out.

Health Outcomes

Health in this model reflects the understanding of health held by the focus group participants. The participants defined health as, "wholeness of the spirit. Mind, body, and spirit"; "a general sense of well-being"; and "spiritual,

emotional, physical, mental well-being.” Initial efforts in our iterative data analysis process to separate these different kinds of health failed, in that arrows went from nearly every SEF condition and mediator to every kind of health. Ultimately, we believe the data suggest that physical and mental health and spiritual well-being are inextricably intertwined, with the result that their potential antecedents likely impact more than one kind of health outcome, too. Thus, the model depicts their overlap.

It is interesting, although not surprising, that participants repeatedly included spiritual well-being in their definition of health. Although spiritual well-being may not have the rigorous definition and tradition of physical and mental health, participants considered it essential and described it as different from spiritual self-care practices such as prayer. Participants referred to “spiritual well-being” but did not explicitly define it. It appears, given the context of comments in the transcripts, that participants intended a definition of spiritual well-being similar to that of Ellison (1983): a relationship with God that includes a vibrant sense of life purpose and meaning. Ellison describes spiritual well-being as differing from spiritual health, which he sees as the underlying state, that is itself expressed as spiritual well-being. This view approximates the conceptualization of our participants, which assumes that clergy universally have a strong spiritual foundation, and that spiritual well-being is the fluctuating expression of this foundation. It is worth noting that the United Methodist Book of Worship includes a similarly broad definition of health and well-being.

Discussion

The theoretical model of clergy health presented here was developed from new qualitative data, although many of the conditions and mediators are consistent with results from other studies. It is therefore useful to reflect on expected model elements versus surprises.

Among the expected elements is unrealistically high expectations for oneself (Hall, 1997), which other researchers have found to be related to pastor stress and depression (Ellison & Mattila, 1983). Difficulties in setting boundaries is also well-documented for pastors (Meek et al., 2003), who tend not to admit to role strain for social desirability reasons (Rayburn et al., 1986), and who have a strong servant orientation, putting the needs of others ahead of their own (Darling et al., 2004). Previous research has also shown the negative relationship between clergy well-being and issues of lack of privacy or intrusiveness (Morris & Blanton, 1994; Lee, 1999). Other researchers have recommended conflict resolution training for pastors, due to the difficulties they face handling conflict (Ellison & Mattila, 1983). Much has been written regarding the work complexity and number of roles that pastors hold, with an emphasis on the high demands of the pastorate (Greenberg, 1990; Henry, Chertok, Keys, & Jegerski, 1991; Ostrander, Henry, & Fournier, 1994), which might be expected to impact health. Other studies have also noted the potential for social isolation and lack of close friendships among clergy (Blackbird & Wright, 1985; Meek et al., 2003; Warner & Carter, 1984).

Researchers have also explored the role of congregational health and criticism or support from laity, in relation to clergy health (Krause, Ellison, & Wulff, 1998). The comments participants made about church health affirm the anecdotal evidence of church climate described in popular writing by Rediger (Clergy Killers, 1997; *The Toxic Congregation*, 2007). The three examples of difficult church dynamics that emerged from our data fit into Rediger’s “toxic congregation” category in which congregants exercise a substantial amount of control in enacting an agenda

that is divisive or harmful to the church (Rediger, 2007). Our participants recognized, as Rediger does, that there is a continuum of toxicity (Rediger, 2007). Overall, our findings on church health and the large number of expected elements lends validity to this study's data.

The data also revealed several unexpected elements of clergy health. For example, pastors reported that when their congregants commented on and directly supported their self-care practices, they felt more apt to engage in self-care. Although we often think of leadership as flowing from pastors to the laity, this finding indicates that leadership can also go the other direction, particularly when pastors feel like they need permission to stop serving others and care for themselves. Our clergy participants also reported that their congregations have a shallow understanding of pastors' roles, sometimes perceiving that pastors only preach and make rounds with ill members. Congregant expectations of pastors are likely to be unrealistically high and broad if they perceive pastors as having substantial free time. Simultaneously, our participants indicated that they have less volunteer help available to them than in the past, and furthermore, that congregants look to them as paid professionals to take on any undone tasks. Fewer volunteer hours in church settings have been previously documented (Carroll, 2006); however, a connection to pastor health may be new.

Among the 42 moderators of health that our model categorizes, participants perceived that the ones most impacting their health are: lack of boundary-setting, congregants' perception that pastors are constantly available, financial strain, church health, and itinerancy. Quantitative data are needed to test the relative contribution of each proposed condition to clergy health. Health research indicates that money is indeed linked to health (Marmot, 2002; McDonough, Duncan, Williams, & House, 1997), as is stress (S. Cohen, Doyle, & Skoner, 1999; McEwen, 2003; Merz et al., 2002) and its flip side, relaxation (Astin, Shapiro, Eisenberg, & Forsys, 2003). The moving inherent in itinerancy may disrupt one's usual source of care; having a usual source of care is associated with more recommended preventive services and improved health status (DeVoe, Fryer, Phillips, & Green, 2003; Doescher, Saver, Fiscella, & Franks, 2004; Sarver, Cydulka, & Baker, 2002), whereas disruptions may result in poor health outcomes (Shea, Misra, Ehrilick, Field, & Francis, 1992). Moving may also contribute to loss of social support, which has been demonstrated to impact health (Cassel, 1976; Cobb, 1976; S Cohen & Wills, 1985; House, Landis, & Umberson, 1988). Thus, participant perception may prove accurate in a quantitative test of the model. The value of the qualitative data presented here is that it allowed us to uncover the pressures and beliefs that clergy experience and put them into a unified model.

The data exposed a number of policy implications. First, it appears that many clergy are not utilizing their conferences' vacation policies, which may take a toll on health. Second, we found that both pastors and DSs believe that DSs rarely communicate the importance of self-care to pastors. The connectional system in which pastors report to DSs provides both an opportunity and a stress point for pastor health. It provides an opportunity insofar as pastors might be more willing to engage in exercise and other self-care practices if they believe that their DS prioritizes their health and is willing to minimize some pressures they feel in order to free up their time for self-care practices. DSs have direct access to UMC churches and the leadership structures within those churches to advocate for the need for pastors to tend to their health. In the focus groups, DSs expressed interest in using these avenues to help laity understand the need for pastors to protect personal time. The stress point in the connectional system is that pastors may overwork, to the neglect their health, if they perceive that is what their peers do and what their DSs require.

Third, our data suggested that some pastors experience high stress and overwork, whereas others have found ways to maintain less stressful pastorates. Peer support may help pastors learn ways of handling their unique demands and stresses; however, our data suggest that peer support is likely to be more effective if it occurs in a way that allows

pastors to make themselves vulnerable to each other and ensures confidentiality, especially with pastors who are later promoted to DS. Fourth, training for pastors on boundary-setting and conflict resolution skills might be helpful, but only if higher-level support for pastors protecting personal time is made clear to both pastors and congregations. Fifth, Annual Conferences might consider ways to improve the health of the churches that make the life—and health—of pastors miserable. Sixth, a change in the UMC compensation structure to pay based on number of years experience, rather than church assignment, might decrease resentment and competition between pastors, and might make pastors more willing to seek mental health services because any consequent stigma would not affect their future salary.

Finally, the UMC itinerant system places large stressors on the health of pastors and their families. Some of these stressors are inherent in relocating regularly, and may be felt by business executives and other professionals who also face frequent relocation. Nevertheless, the UMC system of itinerancy is in important ways an eighteenth-century system of pastoral appointment set now in a twenty-first century context, where the tension between mobility and rootedness creates new challenges. Perhaps the question concerns not so much itinerancy itself as a rethinking of what a commitment to an itinerant system means in this new context. Even within the itinerant structure, processes could be put in place to allow pastors and their families to grieve the losses involved in moving. For example, pastors could be given a month transition time before engaging with the new church. Special attention could also be paid to the amount of notice pastors have that they will be moving. Ideally, the interval of time between the announcement of the pastor leaving and the pastor actually leaving is long enough to allow for grieving, but this does not always happen. Obviously, the UMC could also lengthen the average length of stay at a given church.

Some of the conditions in the model may be particular to UMC clergy, and others may be experienced by people in other occupations. For example, feelings of competition with one's peers and the desire to appear successful to one's supervisor are true for people in many occupations. The difference among clergy is that they may be operating under the assumption that feelings of brotherly love should trump feelings of competition. Similarly, the pastor-supervisor relationship may be different from that in other occupations, because in the UMC, pastors are encouraged to be completely honest with their supervisor in order to be evaluated for fitness to pastor. The conflicting roles in this case may enhance stress.

We hope that having a single compilation model of clergy health will enhance the overall understanding of clergy health; foster studies on specific antecedents to clergy health; and guide the design of interventions to promote clergy health. In addition, perhaps the most useful aspect of this model will prove to be the interweaving of the multiple levels that impact clergy health. For example, the civic community level norms around food inevitably affect congregational food norms. Perhaps more specifically to United Methodism, concerns about future church assignments in the itinerant system (Institutional level) may lead pastors to seek less support from DSs in charge of these assignments, and less support from other pastors who may be promoted to DS (Interpersonal level). These examples highlight the need to consider multilevel interventions, which studies have shown to be more effective than interventions at a single level (Reger-Nash, Bauman, Cooper, Chey, & Simon, 2006).

This model is specific to United Methodist clergy because 1) our data were drawn from UMC clergy and 2) it is important to consider the institutions and contexts within which individuals live. In particular, some of the Institutional level conditions in this model are likely to be unique to UMC clergy. For example, the existence of DSs as “mid-level” managers, while perhaps not unique, is certainly not common in other denominations. It was evident in both the clergy and DS focus groups that the institutional role of the DS within the UMC may be helpful or harmful for pastor health.

As with itinerancy, the office of the DS harks back to the eighteenth century and is likely in need of adjustment. Of course, such adjustments are by no means unfamiliar to the UMC, which has adapted to changing contexts in the past. We hope that the way we organized the conditions highlights some of the ways in which the UMC in particular, as an institution, can work to address the health of its pastors.

Participants' conception of health as holistic and therefore as inclusive of spiritual well-being may also be due to the sample of UMC clergy. The theological tradition of United Methodism is rooted in the works of John Wesley (1703-1791). Wesley had a rich conception of holistic health (Maddox, 2007), and for this reason it is not surprising that participants included spiritual well-being in their definition of health.

It is possible that a large number of the conditions proposed here apply to other religions and denominations, but further research is needed. Research on other religions and denominations may find the most differences in the Institutional level.

This study's limitations are primarily that the data are limited to UMC clergy and do not include quantitative data. Qualitative data are often desirable for theory generation, and this study's large number of focus groups and the diversity of their participants, which included DSs as well as pastors, provided rich qualitative data. In future research, quantitative data should be used to test the relationships in the proposed model. Another study limitation is that we were not able to analyze specific quotes based on pastor career stage. It is entirely possible that the relevance of certain proposed conditions differ by number of years in ministry; this is another potentially fruitful area for future research.

Conclusion

Concern for the health of clergy has been neglected, possibly because the clergy position is so other-oriented as to stave off concern for them, and possibly due to the better overall mortality rates experienced by clergy. Nevertheless, there are reasons to be concerned about the health of clergy, and clergy health interventions should consider the beliefs and pressures that are particular to clergy. The proposed theoretical model reflects holistic health as conceptualized by UMC clergy and offers numerous avenues of intervention to sustain and promote clergy health. Theoretically-based interventions are needed, along with their rigorous evaluation.

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