

Clergy Wellness: An Assessment of Perceived Barriers to Achieving Healthier Lifestyles

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Abstract This study sought to obtain a better understanding of how clergy view their health and to investigate their self-reported health status. Additionally, this study sought to explore personal and professional barriers among clergy to living a healthier life. An electronic 32-item survey was sent to all practicing clergy in Kansas East and West conferences of United Methodist church by the Kansas Area Office of the United Methodist Church. Survey items included participants' demographic information and health conditions (e.g., diabetes, heart disease, high blood pressure, high cholesterol). The self-reported general health, mental health, and physical health data were also collected to compare to the general population in Kansas. Clergy were also asked to identify perceived barriers to health. A total of 150 clergy participated in the survey. The majority (93.7 %) self-reported their health as *good*, *very good*, or *excellent*. Participating clergy self-reported a higher prevalence of chronic diseases (diabetes, heart disease, high blood pressure, and high cholesterol) than the Kansas general population, but those differences were not statistically significant. More than three-fourths (77.4 %) of the participating clergy reported weights and heights that classified them as either overweight or obese. Lack of family time was the most frequently reported personal barrier to achieving a healthier lifestyle. An unpredictable work schedule was reported as the most frequent professional barrier to achieving a healthier lifestyle. This study suggests that Kansas clergy generally view their overall health status favorably despite being overweight or obese. Clergy also self-reported higher prevalence of chronic diseases than the general Kansas population, though the prevalence was not statistically different. This study provides additional insight into clergy

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health and offers suggestions to address the barriers preventing clergy from working toward better health.

Keywords Clergy · Wellness · Barriers · Health

Introduction

In 2007, there were approximately 622,000 clergy serving all denominations and traditions in the USA (Lindner 2009). These clergy serve an estimated 339,000 churches, with more than 152 million members (Lindner 2009), constituting 49 % of the US population in 2010 (US Census 2010).

The clergy vocation is unique in its diverse range of professional responsibilities. Clergy are inherently exposed to a lifestyle that is hectic, fragmented, and emotionally challenging, and it has little structure or predictability (Kuhne and Donaldson 1995). Despite the varied responsibilities of the vocation, most clergy are committed to their calling and feel a deep sense of commitment to the people and to the God they serve (Proeschold-Bell and LeGrand 2010). This passion may make it difficult for them to set necessary boundaries between their work and their personal lives (Proeschold-Bell and LeGrand 2010). Personal criticism, boundary ambiguity, presumptive expectations, and demanding congregations can lower pastors' overall life satisfaction (Lee and Iverson-Gilber 2003). Given the demands placed on clergy, it is realistic to predict a certain degree of emotional stress and to assume that this stress has an effect on clergy members' sense of well-being. Despite a well-documented understanding of the connection between the clergy vocation and emotional health (Celeste et al. 1995), there is little known about the association between clergy and their physical health.

One study suggests that clergy have unfavorable mortality rates for specific diseases, particularly hypertension and diabetes (Flannelly et al. 2002). Another study suggests the prevalence of obesity for North Carolina United Methodist clergy was 40 %, significantly higher than that of the general North Carolina population (29 %) (Proeschold-Bell and LeGrand 2010). Similarly, a study of 1,853 United Methodist clergy suggested that they experienced higher rates of hyperlipidemia, pre-hypertension, and pre-diabetes when compared to a matched sample of US adults (General Board of Pensions 2012).

In an effort to combat this trend of chronic health risks facing clergy, various denominational programs within the United Methodist Church have been developed. Likely, the most sophisticated program of its kind, the Duke Clergy Health Initiative Program, implements a three-step process: (1) Pastors obtain a physical exam from a physician; (2) pastors are paired with a health coach who facilitates behavior change by setting goals and creating coherence between those goals and the pastors' values; and (3) pastors explore financial assistance and establish an accountability system to support them to think about their health in a holistic and theological context (Wallace et al. 2012).

Modeled, in part, after the Duke program, the United Methodist Health Ministry Fund (UMHMF) in Kansas developed a three-step clergy wellness program. In the first step of the UMHMF program, clergy participate in a personal online health risk assessment, provide their annual physical examination results to program staff, and have blood tests conducted. Step two is a retreat-style gathering where clergy attend a self-care workshop featuring health information tailored for professional clergy, consult with a physician,

financial planner, spiritual counselor, personal health counselor, nutritionist, and physical therapist who have had prior access to the step-one assessments, and then develop a personal health plan in conjunction with their personal health counselor based on their consultations with all of the health professionals in attendance. Step three involves individual annual face-to-face interaction with a personal health counselor to assess progress on the health plans followed by group conference calls with the personal health counselor over a 6- to 12-month follow-up. These interactions feature the development of a personal plan of action during the face-to-face encounter with the personal health counselor followed by motivational interviewing and group accountability via follow-up conference calls.

This study sought to assess participants' perceptions of their own health status to: (1) obtain a better understanding of how clergy view their health and to investigate their actual health status, (2) identify the barriers they perceive that may prevent them from achieving a healthier lifestyle, and (3) identify potential opportunities to reduce barriers to clergy in obtaining a healthier lifestyle.

Methods

This study was designed as a cross-sectional survey, using qualitative and quantitative data. The study protocol was approved by the Human Subjects Committee at the University of Kansas School of Medicine–Wichita (KUSM-W).

Participants

Participation in this study was limited to United Methodist ministers serving the Kansas East or West conferences of the United Methodist Church in February 2013. All potential participants were contacted via e-mail once from the administrative office of the Kansas Area of the United Methodist Church, which utilized its own database of active clergy. To ensure participants' anonymity and to protect their privacy, investigators did not have access to clergy e-mail or other contact information. No incentives were provided to the participants of the study.

Instrument

The instrument was a 32-item internet-based survey of all active Kansas UMC clergy. Survey questions were either multiple choice ($n = 16$), open ended ($n = 15$), or formatted using a five-point likert-type scale ($n = 1$). The instrument was designed to acquire relevant self-reported data on and perceptions of clergy health status and to assess perceived barriers and potential solutions to achieving improved health.

Topics addressed in the survey included the perception of clergy's current health status, personal and professional barriers to seeking a healthier lifestyle, demographic variables including age, gender, race, and the size of community in which the pastor resides, and the average attendance for the church in which he or she serves. Individuals were also asked to self-report their height and weight. When appropriate, questions centering on health perception were designed to be similar (or identical) to questions from the Centers for Disease Control and Prevention's—Behavioral Risk Factor Surveillance System (BRFSS) for comparison purposes. Survey items focused on healthier lifestyle barriers were constructed to be consistent with previous research (Proeschold-Bell et al. 2011).

Procedures

Initial contact with potential participants was in the form of an e-mail from an official of the Kansas United Methodist Church, inviting the individual to participate in the study. Within that e-mail, there was a letter from the researcher explaining the purpose of the research and a link to the instrument on the electronic survey provider, Survey Monkey. Clergy who wished to participate then utilized the link to complete their survey anonymously.

Analysis

The aggregate data were analyzed using IBM SPSS software v. 20. Descriptive statistics were used to categorize responses. Continuous variables were reported as means and standard deviations, and discrete variables were reported as counts and percentages. To calculate the body mass index (BMI), the formula (weight in pounds/height in inches² × 703) was used. Overweight was defined as BMI 25–29.9, and obesity as BMI 30.0 or greater.

A dichotomous variable was created based on the question “Would you say that in general your health is fair, poor, good, very good, or excellent.” The choices were collapsed into two categories: good, very good, or excellent, and poor or fair. Chi-square analysis was conducted to assess whether or not there was a difference between the clergy and general Kansas population on the self-reported general health (good, very good, or excellent vs. fair or poor), BMI categories, chronic disease status (diabetes, heart disease, high blood pressure, and high cholesterol). A zero-inflated Poisson regression analysis was conducted to explore whether there was a difference between the number of physically and mentally unhealthy days within the past month between the two groups. All statistical analyses were two-sided. *p* value ≤ 0.05 was considered significant. Qualitative data were analyzed to identify emergent themes.

Results

Demographics

The invitation to participate in the survey was e-mailed to all 435 active clergy within the Kansas East and Kansas West Conferences of the United Methodist Church. The total number of respondents was 150, for a response rate of 35 %. E-mail survey rates have consistently declined from 61 % in 1996 to 24 % by 2000, so a response rate of 35 % actually exceeds the prevailing trend for e-mail survey response rates (Bartel Sheehan 2001). More than half (57 %) of the respondents reported being male, and 95 % reported being Caucasian (Table 1). This percentage varied slightly from the overall composition of Methodist Clergy in the state of Kansas, who are 62 % male. Respondents' ages ranged from 26 to 83 years, and the mean age was 55 years, which was very similar to the percentages of all Methodist clergy in Kansas, whose average age is 53.9 years. Among those who responded, 63 % (*n* = 90) stated they were fully ordained itinerant clergy, whereas the remainder reported being licensed local appointed clergy or some other clergy position within the church. In regard to marital status, 83.3 % (*n* = 125) were currently married, and 7.3 % (*n* = 11) were currently divorced.

Respondents reported spending an average of 4 (±3) days with family or friends in the past 30 days. When asked about their Sabbath practices, the average number of days taken off work and respected as a Sabbath was approximately 3 (±4) days in the past 30 days.

Table 1 Respondents' self-reported demographics

	Kansas Methodist clergy (<i>N</i> = 150)
Gender	
Male	86 (57.3 %)
Female	64 (42.7 %)
Race	
Caucasian, White	142 (94.7 %)
African-American, Black	4 (2.7 %)
Asian-American	2 (1.3 %)
Native Hawaiian or other Pacific Islander	2 (1.3 %)
American Indian, Alaska Native	0 (0.0 %)
Hispanic	
Yes	3 (2.0 %)
No	147 (98.0 %)
BMI category	(<i>n</i> = 146)
Underweight (BMI < 18)	0 (0.0 %)
Normal weight (BMI 18–24.9)	33 (22.6 %)
Overweight (BMI 25–29.9)	54 (37.0 %)
Obese (BMI ≥ 30)	59 (40.4 %)
Healthcare coverage	
Yes	148 (98.7 %)
No	2 (1.3 %)
Age (in years)	(<i>n</i> = 143) ^a
18–25	0 (0.0 %)
26–34	15 (10.5 %)
35–44	13 (9.1 %)
45–54	31 (21.7 %)
55–64	53 (37.1 %)
65–74	26 (18.2 %)
75 or older	5 (3.5 %)
Size of community	(<i>n</i> = 143) ^a
<2,500	46 (32.2 %)
2,500–49,999	48 (33.6 %)
≥50,000	49 (34.3 %)
Position in the church	(<i>n</i> = 144) ^b
Itinerant clergy	90 (62.5 %)
Appointed clergy	32 (22.2 %)
Neither/other	22 (15.3 %)
Marital status	(<i>n</i> = 150)
Married	125 (83.3 %)
Divorced	11 (7.3 %)
Widowed	4 (2.7 %)
Separated	0 (0.0 %)
Never married	10 (6.7 %)

^a Missing 7 responses^b Missing 6 responses

Health Status

Regarding perceived health status of all respondents ($N = 143$), a total of 134 (93.7 %) self-reported their general health as good, very good, or excellent, and nine (6.3 %) indicated they were in fair or poor health (Table 2). More than three-fourths (77.4 %) of respondents reported heights and weights that corresponded with overweight or obese body mass indices (BMIs, Table 2). The average self-reported BMI was 29.81 kg/m^2 ($SD = 6.48$), which was higher than the general population of Kansas (mean = 28.00, $SD = 6.33$, $p = 0.0006$) (Centers for Disease Control and Prevention, 2013).

Clergy were also asked to report the number of days, in the past 30 days, that their physical, mental, or spiritual health was not good (Table 2). In regard to physical health, study respondents reported their physical health as “not good” an average of 3.09 days. Similarly, they reported mental health as “not good” an average of 2.86 days and spiritual health that was reported as “not good” an average of 2.67 days. Neither the physical nor mental health measures were significantly different from the general Kansas population. Spiritual health measures for the general population of Kansas were not asked on the BRFSS, so no comparison is possible.

In addition to perceptions of their own health, clergy were also asked whether they had ever been told by a healthcare professional that they had specific chronic health conditions, including diabetes, heart disease, high blood pressure, and high cholesterol. High blood pressure (36 %) was the most predominant condition reported followed by high cholesterol (34 %), diabetes (11 %), and heart disease (6 %). Clergy self-reported higher prevalence of chronic disease (diabetes, heart disease, high blood pressure, and high cholesterol) than the general Kansas population, but the differences were not statistically significant (all p values > 0.05).

Perceived Barriers to Improved Health

Clergy were asked to identify professional and personal barriers to living a healthier lifestyle. Regarding personal barriers, 56 of the 150 (37 %) respondents reported a perception of at least one barrier (Table 3). Lack of family time was the most frequently reported personal barrier ($n = 27$ of 56, 48 %). This was followed by limited access to fitness equipment ($n = 18$ of 56, 32 %), and the lack of a spiritual director ($n = 13$ of 56, 23 %).

Additionally, 75 of the 150 (50 %) respondents indicated the presence of at least one professional barrier. Out of the 75 respondents who identified a barrier, 59 of 75 (79 %) clergy identified an unpredictable work schedule as a professional barrier. This was followed by the response of being overwhelmed by the needs of the congregation ($n = 33$ of 75, 44.0 %) as the second most reported professional barrier.

Potential Solutions to Address Barriers

Study participants were asked to choose from a list of various potential solutions that may enhance their ability to achieve a healthier lifestyle, by selecting all that applied. Approximately one-third (36.7 %) stated that financial incentives could help them achieve a healthier lifestyle (Fig. 1). Other frequently mentioned potential solutions included: a cultural change from church hierarchy (31.3 %), access to a spiritual advisor (26.7 %), or

Table 2 Comparison of health between the general population in Kansas, and Kansas United Methodist clergy

	Kansas BRFSS data (unweighted $N = 20,172$; weighted $N = 2,140,910$)	Kansas Methodist clergy ($N = 150$)	p value
General health			
Excellent, very good, or good	1,815,688 (85 %)	134 (93.7 %)	0.0035
Fair or poor	320,445 (15.0 %)	9 (6.3 %)	
Physical health			
Number of days physical health is not good within the past month, mean (95 %CI)	3.41 (3.28, 3.54)	3.09 (2.28, 3.90)	<0.001 ⁺
Mental health			
Number of days mental health is not good within the past month, mean (95 %CI)	3.31 (3.17, 3.45)	2.86 (2.20,3.52)	0.250 ⁺
Spiritual health			
Number of days mental health is not good within the past month, mean (95 %CI)	Not included in the BRFSS	2.67 (1.87, 3.47)	N/A
<i>Other health conditions</i>			
BMI Category			0.0028
Underweight (BMI < 18)	36,641 (1.8 %)	0 (0.0 %)	
Normal weight (BMI 18–24.9)	681,910 (33.8 %)	33 (22.6 %)	
Overweight (BMI 25–29.9)	703148 (34.8 %)	54 (37 %)	
Obese (BMI ≥ 30)	596,414 (29.6 %)	59 (40.4 %)	
Diabetes*			0.5010
Yes	203,216 (9.7 %)	17 (11.3 %)	
No	1,890,366 (90.3 %)	133 (88.7 %)	
Heart disease			0.3884
Yes	96,461 (4.5 %)	9 (6 %)	
No	2,030,674 (95.5 %)	141 (94 %)	
High blood pressure			0.2386
Yes	658,386 (31.5 %)	54 (36 %)	
No	1,429,826 (68.5 %)	96 (64 %)	
High cholesterol			0.2679
Yes	605,244 (38.4 %)	51 (34 %)	
No	970,918 (61.6 %)	99 (66 %)	

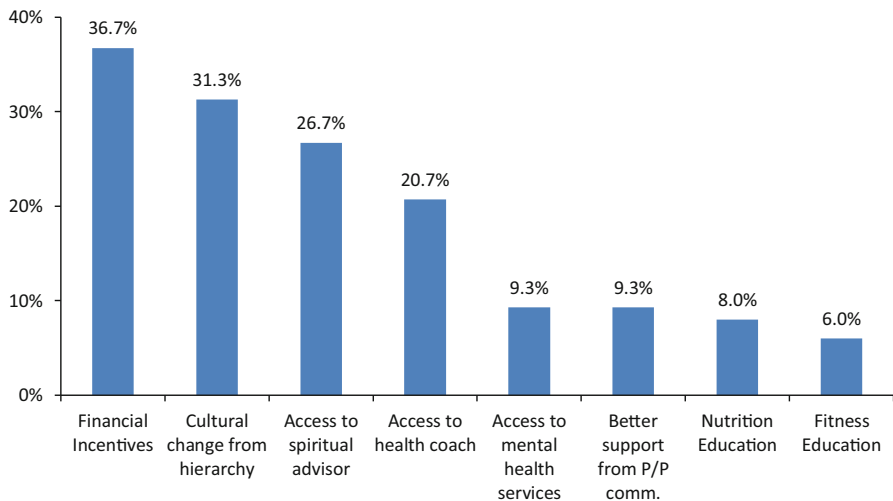
* BRFSS data have four possible responses to the diabetes questions, which include “yes,” “Yes, but female told only during pregnancy,” “no,” and “No, pre-diabetes or borderline diabetes.” For the comparison, we only include the “yes” and “no” response to the diabetes question

⁺ The p values were calculated based on the zero-inflated Poisson regression analysis

having access to a health coach (20.7 %). Of the remaining four other items respondents could have selected as a potential solution, no single item was selected by even 10 % of the respondents. Among those who identified potential solutions, there was some variation based on the size of the community in which respondents lived. For instance, among the 55

Table 3 Self-reported barriers to a healthier lifestyle

Personal barriers identified	Clergy who identified barriers
	<i>n</i> = 56
Lack of family time	27/56 (48.2 %)
Limited access to fitness equipment	18/56 (32.1 %)
Lack of spiritual director	13/56 (23.2 %)
Financial factors	12/56 (21.4 %)
Lack of family privacy	10/56 (17.9 %)
Lack of knowledge/nutrition	4/56 (7.1 %)
Limited access to medical care	3/56 (5.4 %)
Lack of knowledge/exercise	2/56 (3.6 %)
Lack of access to mental health services	2/56 (3.6 %)
	<i>n</i> = 75
Unpredictable work schedule	59/75 (78.7 %)
Overwhelmed by needs of congregation	33/75 (44.0 %)
Unrealistic expectations of congregation	23/75 (30.7 %)
Unhealthy hospitality	19/75 (25.3 %)
Putting others needs before own	18/75 (24.0 %)
Frequent relocation	6/75 (8.0 %)

**Fig. 1** Potential “solutions” to assist in achieving a healthy lifestyle

who indicated that financial incentives would enhance their ability to achieve a healthier lifestyle, 27.3 % reported living in communities with populations of less than 2,500, whereas 41.8 % reported living in communities with populations of 50,000 or more (Table 4).

Table 4 “Solutions” to assist in achieving a healthy lifestyle by community size

“Solution” for healthy living	Less than 2,500	2,500–49,999	50,000 or more	Total
Financial incentives to join a fitness club or participate in a wellness program	15 (27.3 %)	17 (30.9 %)	23 (41.8 %)	55 (100 %)
A culture change within the church hierarchy promoting and supporting pastoral self-care	15 (32.6 %)	12 (26.1 %)	19 (41.3 %)	46 (100 %)
Access to a health coach	9 (29.0 %)	9 (29.0 %)	12 (38.7 %)	30 (100 %)
Access to a spiritual advisor	12 (30.0 %)	17 (42.5 %)	11 (27.5 %)	30 (100 %)
Access to confidential mental health services	2 (14.3 %)	5 (35.7 %)	7 (50.0 %)	15 (100 %)
More support from the pastor/parish committee in my church	3 (21.4 %)	6 (42.9 %)	5 (35.7 %)	14 (100 %)
Additional education on proper nutrition	4 (33.3 %)	4 (33.3 %)	4 (33.3 %)	12 (100 %)
Additional education on proper exercise	3 (33.3 %)	2 (22.2 %)	4 (44.4 %)	9 (100 %)

Discussion

Clergy Health

United Methodist Clergy in Kansas were found to have an average BMI higher than the average BMI of the general population of the state of Kansas. Obesity can be related to certain health conditions such as hypertension, hypercholesterolemia, stroke, heart disease, diabetes, certain cancers, and arthritis (Taylor et al. 2009). This finding of a higher average BMI among clergy in the current study is consistent with a 2008 study of North Carolinian United Methodist clergy. Their study suggested that clergy were 10.3 % more likely to be obese but 5.4 % less likely to be overweight than the general population of North Carolina (Proeschold-Bell and LeGrand 2010). Proeschold-Bell and LeGrand 2010 also suggested that there was a significant increase in self-reported chronic disease status among clergy, such as diabetes, arthritis, high blood pressure, and angina, when compared to the general public.

The current study was consistent with those findings of higher chronic disease status among clergy. Self-reported prevalence of diabetes, heart disease, high blood pressure and high cholesterol were compared to the 2011 Kansas BRFSS data. The chronic health conditions examined were more prevalent among Kansas clergy than the Kansas general population, though the differences were not statistically significant. Proeschold-Bell and LeGrand 2010 explored the obesity rate and chronic disease rates in North Carolina. They reported a significantly higher rate of chronic disease among clergy than among the general population in North Carolina. Our findings are consistent with their findings.

Despite having proportionately higher BMIs than the general public in Kansas, clergy indicated that they had fewer days of poor physical health (3.09 ± 5.81 vs. 3.95 ± 8.63 $p < 0.001$) and generally rated their overall health better than the Kansas BRFSS respondents by 11.1 % ($p < 0.001$). This finding could be interpreted that clergy have different perceptions of poor health than the general public. However, this finding could also support a 2013 study which found that grade 1 obesity (BMI 30–35) is not associated with a higher all-cause mortality, and overweight is associated with a modest decrease in mortality (6 %) (Flegal et al. 2013). Although the Flegal et al. study does not address quality of life issues, it and several similar papers (Gaesser et al. 2011; Durazo-Arvizu

et al. 1998; Troiano et al. 1996) raise questions about the value of associating health with body mass index. Regardless of the interpretation, few could argue against the promotion of key health behaviors (e.g., physical activity, eating healthful foods, not using tobacco) that benefit all populations, including clergy. For clergy to improve their health conditions (e.g., hypertension, high cholesterol, type II diabetes, heart disease), perhaps it would be beneficial for health promotional efforts to shift from attempting to address each health condition individually to promoting these key health behaviors.

Barriers to Achieving Better Health

This study sought to identify the barriers that clergy perceived as obstacles which prevented them from achieving a healthier lifestyle. When asked to identify personal and professional barriers, a variety of responses were given. The most common personal barrier reported (48.2 % among those identifying a barrier) was a lack of personal time to spend with family. Limited access to fitness equipment and financial factors were also commonly reported barriers to achieving better health. The most commonly reported professional barrier to achieving a healthier lifestyle was an unpredictable work schedule. Feeling overwhelmed by the needs of the congregation and experiencing unrealistic expectations from church members accounted for the next most common barriers to improved health of pastors. These findings of personal and professional barriers, such as balancing work and family and time management, are consistent with another study of clergy (Proeschold-Bell et al. 2011), although the current study quantifies the barriers experienced.

Stress in the workplace has been found to play a role in chronic health conditions, particularly obesity (Chandola et al. 2006). Despite high job satisfaction, it is well known that clergy lead stressful lives (Doolittle, 2007; Flannelly et al. 2002). Research on job satisfaction in the USA suggests that among all the professions surveyed, clergy were most likely to indicate they (87 % of clergy) were very satisfied with their job, compared with the national average of surveyed professions (47 %) (Smith 2007). These findings are consistent with other research which suggests that stress is somewhat related to working hours, but more strongly to characteristics of the congregation's functioning, including its morale, the presence of conflict, lack of a shared understanding of the role of pastor, and problems with other staff or lay leaders (Royle 2005).

Potential Solutions to Address Barriers

A potential solution that received the largest percentage of response was to have financial incentives offered, for instance, to join a fitness club or participate in a wellness program ($n = 55$, 37 %). This finding is consistent with a study conducted by Proeschold-Bell and LeGrand which suggested that a paid health club membership would be the most valuable incentive to motivate clergy to improve their health. Despite its appeal to clergy, this method is not a strategy used among numerous churches representing multiple denominations (Wallace et al. 2012). Additionally, the size of community in which the respondent lives appears to have a bearing on their perception of the value of financial incentives. Those living in communities with populations greater than 50,000 people are more likely to respond favorably to this particular incentive, as opposed to those living in communities with less than 2,500 people. This would underscore the importance of a comprehensive assessment of the availability of fitness clubs and wellness programs and the practicality of using incentive funds for that purpose. While one size does not fit all, financial incentives to develop healthier lifestyle choices have been shown to be an effective motivator for

promoting healthier behaviors in the workplace (Finkelstein et al. 2008). Examples of this might include employer contributions for membership to a fitness club or reduced health insurance premiums to those participating in a wellness program. Some believe these financial incentives are essential, but compelling exceptions exist. Some employers who oppose financial incentives and who operate successful wellness programs suggest that it is counterproductive to incentivize health behaviors because the employees' focus is on the incentive rather than their health. These organizations have found that corporate and peer recognition for wellness achievements with minimal or no cash rewards attached allow the employees to focus on their health and are more effective (Tu and Mayrell 2010).

Other commonly cited responses by clergy included: (1) a cultural change from within the hierarchy of the church, where pastoral care is more strongly supported and promoted; (2) access to a spiritual advisor; and (3) access to a health coach. Many of these suggestions are consistent with the recommendations offered by The Church Systems Task Force: a joint task force of the General Board of Pension and Health Benefits and the General Board of Higher Education and Ministry (General Board of Pensions 2011). Five recommendations, some of which were related to our survey data, were offered: (1) provide more assistance to those entering the clergy by incorporating health and spirituality into seminary curricula and establishing a provision for either career-long mentoring or spiritual guidance apart from the district superintendent, (2) establish guidelines for a healthy work/life balance, (3) change the itinerancy and appointment-making process to mitigate stress on clergy, (4) redefine the role of the district superintendent to be more of a coach or mentor who provides feedback in the monitoring of clergy wellness, and (5) provide assistance for a grace-filled transition to those pastors who no longer hear a call to minister and who are voluntarily exiting the ministry.

Other denominations have system-wide policies focused on clergy health. A review of 56 clergy health promotion programs suggested that all had health resources for clergy and laity, but few had specific programs to promote clergy's health (Wallace et al. 2012). Providing education on fitness and nutrition is commonly offered through these church-sponsored programs. However, the current study suggests that clergy do not identify such educational programs as important as receiving financial incentives to join fitness clubs or participate in wellness programs. Therefore, this study has important implications for the development and implementation of wellness initiatives for clergy.

Limitations

This study was limited by a sample size of 150 clergy. Several steps were taken into consideration to help increase participation. First, the survey e-mail invitation was originated from the Bishop's office, rather than from the research team. This was thought to increase the likelihood of a higher response rate. Secondly, we chose to deliver the e-mail during a season when the pastor may have fewer commitments.

Measurement bias was possible; self-reported measurements (height, weight) may not be entirely accurate. Recall bias and a tendency to give socially desirable answers or portray one's self in the best possible manner are risks with self-reported health measures, but to help combat this risk, we included specific directions or definitions to obtain those measurements when possible. Additionally, clergy could be subject to a response bias, by giving only morally correct answers to the questions. To address this concern, clergy were assured that their responses were entirely anonymous. Also, without repercussion, they could avoid answering any question that made them feel uncomfortable. Finally, volunteer bias was possible; the most eager to speak out might have been more likely to respond to

the survey. To try to account for this we invited all clergy to participate and offered an appeal, that it was for the good of the Church, in hopes that this would encourage a diverse response.

Conclusions

This study suggests that clergy generally view their overall health status quite favorably. However, this study provides evidence that clergy are at risk of overweight and obesity and their self-reported prevalence of certain chronic diseases was also higher than prevalence among the general population in Kansas. The barriers to a healthier lifestyle that were identified by participating clergy include various personal and professional challenges that are generally related to time constraints, expectations of others, and financial concerns. Mechanisms proposed by respondents to address these barriers included financial incentives to join a fitness club or participate in a wellness program, and a cultural change from within the hierarchy of the church supporting enhanced clergy self-care. This study provides insight into clergy health and offers suggestions to address the barriers preventing clergy from achieving better health. Church administrators and other individuals involved in the development of clergy wellness initiatives can use this information to structure meaningful and effective interventions.

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