

CHECKING UP ON CLERGY HEALTH ASSESSING THE COST OF SACRED WORK

Many people feel called to their work and respond to job demands in ways that reflect a sense of vocation. But do we expect clergy to perform their calling with even greater devotion and sacrifice? Because clergy define their work as sacred, taking care of themselves may always be a lower priority. One writer describes the high cost of sacred work in this way: “if your backdrop is burning bushes and having a child at age ninety, or if it’s bumping into an angel with premarital plans for you . . . who are you to turn down a relatively minor request like leaving vacation to perform a funeral?”¹

The Latest Numbers

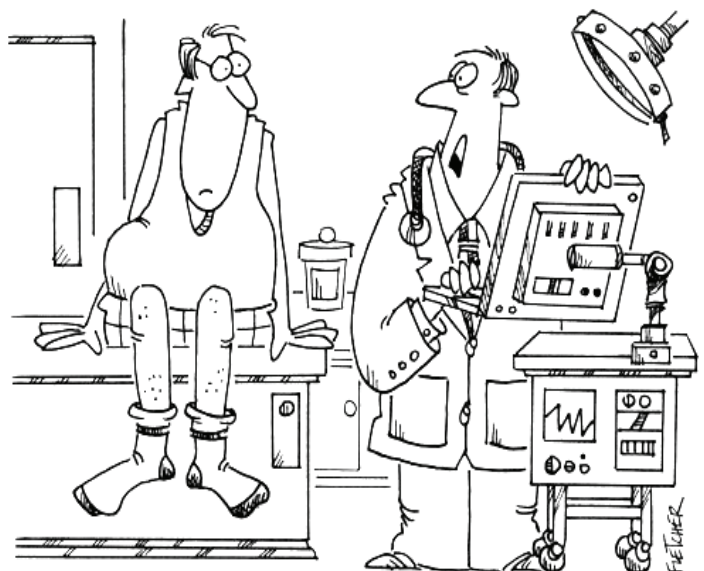
Findings from a ten-year, longitudinal study suggest that unraveling all the complexities of clergy health and well-being is not easy. Although the study drew from a large number of United Methodist clergy, the research results mirror findings from other Protestant clergy samples. This landmark study also carefully tracked intervention efforts and evaluated how individual clergy might change their health status and habits over time.²

Physical health. Just as health insurance costs for the general population continue to climb, the same holds true for clergy. In fact, these costs for clergy remain higher, partly because clergy submit more health care claims.³ National studies reveal clergy have higher rates of obesity than the general population, regardless of age. Obesity causes and complicates other health issues, especially chronic diseases, such as diabetes, arthritis, asthma, and heart disease.⁴ Lack of exercise and a damaging diet contribute to weight gain as well as high blood pressure, high cholesterol, stress, and other health negatives.

Mental health. Levels of depression among clergy remain higher than the U.S. population as well. The study found 8.7% of clergy suffer from some depression (compared to 5.5% of the U.S. population). Both male and female clergy demonstrated these higher-than-average rates of depressive symptoms. This surprising finding runs counter to what appears in the general population, where

females typically present much higher depression rates than males. However, among clergy, the opposite pattern surfaces: twice as many male clergy report depressive symptoms compared to males in the U.S. (8.8% to 4.4%).⁵

What might be some of the causes behind these higher clergy depression rates? There are probably more reasons than can be explored here, but some possibilities include aging (the average age of clergy continues to scale upward), side effects of medications, long hours, presence of congregational conflict, unrealistic clergy expectations about ministry, excessive demands by congregants, and serving as the first line of support in difficult life circumstances (illness, death, divorce).⁶ Yet another factor could be self-selection. Some clergy who went through traumatic life events may seek out ministry as a healing experience. Their own life encounters could make them especially sympathetic to others’ suffering and form their approach to ministry. Henry Nouwen wrote about “the wounded healer,” who exemplifies how one’s own suffering can serve as a source of strength and hope for others.⁷



“WALKING THE WALK ISN’T ENOUGH...
IT’S TIME TO TRY SOME LIGHT JOGGING.”

The good news: More than two-thirds of the study's clergy qualified as "flourishing" compared to only about half of the U.S. population. Clergy are more likely to report being happy, satisfied with their life, filled with a sense of direction and meaning, and enjoying many warm and trusting relationships.⁸ What appears to be a contradictory finding, given the higher-than-average depression rates, confirms what other researchers discovered. Clergy consistently demonstrate remarkable resiliency and better-than-average psychological and social functioning. These measured positives simply do not lie on the same continuum as depression, anxiety, or stress.

Hope-Filled Implications

What do these recent results say to clergy, those who care about them, and those who wish to see congregations strengthened by healthy leadership?

For clergy. After hearing about the health initiative, large numbers of clergy wanted to participate in the health program—so many that new groups had to start in waves every six months. The protocol called for assessment on key components of physical health once they agreed to participate, including weight, waist circumference, blood pressure, HDL cholesterol, and triglycerides. Even before clergy began to participate fully in the program, they showed significant improvements in these metabolic syndrome indicators, which are linked to heart disease, stroke, and diabetes. Awareness and frequent monitoring of physical health indicators resulted in improved outcomes and seeing improvements helped motivate pastors to stick to an exercise plan and continue healthy eating. Screening for potential risks and access to health care is essential for long-term outcomes.

Unfortunately, the program failed to decrease rates of depression or stress symptoms. Although pastors were encouraged to nurture their family and friendships, other components of mental and social health—financial and other context stressors—went largely unaddressed.⁹ These findings underscore that clergy cannot obtain better health alone without the support of congregations and their denominational leaders.

For congregations. Lay leaders play an important role in supporting healthy behaviors in clergy. Encourage the pastor to take a day off a week, pursue a relaxing hobby or interest, get regular exercise, and spend time with family and friends. Other ways to provide stress-reducing support include honoring the boundary between ministry and personal time, offering a

Sabbatical, providing funds for continuing education or personal study (books), or granting time for participation in clergy peer groups.¹⁰ Refrain from insisting that every ministry task is equally important and must be carried out by the pastor. When pastors find ways to spend more time on their joy-filled ministry tasks, they feel greater satisfaction in ministry.

For denominations. The most highly satisfied pastors cite their denomination as a critical partner in their ministry effectiveness. Judicatory leaders can advocate for adequate salaries, housing allowances, healthcare benefits, and pensions, even for clergy in part-time positions. And they can encourage pastors to seek help with physical, psychological, or family issues.

Too many denominations struggle to provide health care resources at the regional or judicatory level. Because the bargaining advantage of national-level organizations yields better and more cost-effective benefit plans, denominations should explore new, national strategies. Further, the obligation to ensure access to full benefits and equal compensation, regardless of age, gender, or race, rests with denominational bodies.

Assessing the Rewards

For clergy: What gives you joy? How does your passion for ministry best connect to your congregation's needs?

For congregations: Have people in the congregation made too many demands on the pastor during the past year? How often have people been critical of things the pastor has done? How does your congregation make the pastor feel loved and appreciated?

For denominations: Do we regularly check in with our clergy to listen to their concerns and needs? How are we planning to improve the ministry environment to promote better clergy health?

1. Rae Jean Proeschold-Bell and Jason Byassee, *Faithful and Fractured: Responding to the Clergy Health Crisis* (Grand Rapids, MI: Baker, 2018), 24.

2. *Ibid.*, xx-xxii.

3. *Ibid.*, xvi.

4. *Ibid.*, 84.

5. *Ibid.*, 37-38.

6. *Ibid.*, 3.

7. Henri J. M. Nouwen, *The Wounded Healer: Ministry in Contemporary Society* (New York City: Doubleday, 1972).

8. Proeschold-Bell and Byassee, 114.

9. Cynthia Woolever, "Big Ministry Trends for 2014," *The Parish Paper*, January, 2014.

10. Cynthia Woolever, "How to Avoid Pastor Burnout," *The Parish Paper*, January, 2013.