An Overview of the History and Current Status of Clergy Health

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Abstract

Clergy have historically lived longer than other white-collar professionals, primarily due to less suicide, accidents, and infectious disease. As the health challenge in the United States has shifted to obesity-related chronic disease, clergy have experienced rates of obesity and corresponding chronic disease that are even higher than those of non-clergy. One possible explanation is the interplay between obesity and stress, and the variety of reasons for clergy stress is discussed. Research on clergy health, holistically defined, is needed. Important gaps in the literature include the health-related experiences of Jewish and Muslim clergy, clergy of diverse countries and cultures, and subgroups of clergy in the United States, including women and African-American clergy. The study of clergy health can shed light on more general research questions, such as the relation between health interventions and spirituality.

Keywords: Randomized controlled trial, multiple baseline design, clergy, metabolic syndrome, depression

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At one time, clergy were thought to be some of the healthiest people in the world. Demographers Haitung King and John C. Bailar, III (1969) searched through four centuries worth of mortality data from nine European countries and the United States and concluded that clergy, up through 1959, lived longer than non-clergy. They also found that clergy lived longer than other white-collar professionals, at least until 1910 when physicians and lawyers began living nearly as long as clergy and teachers began living longer. However, a close look at the data reveals that, although clergy lived longer overall, some clergy died sooner from specific diseases that were either chronic (coronary disease, diabetes) or possibly stress-related (examples using the language of the time include "malfunctioning of the digestive system" and "psychoneurotic disorders"). What clergy have historically been good at is good behavior: fewer accidents, fewer suicides, and less syphilis (King & Bailar, 1969).

Yet in today's society, it is chronic disease related to a generally acceptable behavior—eating—that is killing people in the United States. Among adults aged 20 and above, the prevalence of obesity doubled between 1980 and 2002 (Hedley et al., 2004), and obesity is related to higher rates or exacerbation of a variety of chronic diseases, including diabetes (Taylor et al., 2009), arthritis (Reynolds & McIlvane, 2009), and hypertension (Taylor et al., 2009). It turns out that clergy are not immune to the national obesity epidemic, and may even be more affected by it. A study of 95% of the United Methodist clergy in North Carolina found that the clergy had higher rates of obesity, diabetes, arthritis, and hypertension than other North Carolinians, even after demographic adjustments (Proeschold-Bell & LeGrand, 2010). The clergy obesity rate was a startling 11 percentage points higher (40% versus 29%). Although studies on the physical health of clergy are few, high rates of obesity among Lutheran pastors have also been found (Halaas, 2002).

Why are clergy less healthy? The answer may lie in the stress that clergy face. Among professionals, clergy have a unique set of responsibilities. They are called by God to their vocation, and, for many, this perspective makes them struggle to say no to congregant requests. Clergy also serve diverse roles, from spiritual interpreter, to managers of volunteer congregants, to mentor, counselor, and community leader (Kuhne & Donaldson, 1995). In these roles, clergy often experience role stretch and strain. The skill set needed to interpret the word of God is different from the one needed to manage staff, which is also different from that needed to be a counselor. Even if pastors have all the skills, there is simply a lot expected of them. As one pastor said in a focus group conducted by the Duke Clergy Health Initiative, "Every person sitting in the pew has a separate job description for our job. And when you put it all together, it's an impossible task." Living up to these multiple desires, especially in the context of fulfilling one's call to God, can create enormous stress.

Stress is one aspect of clergy life that has been well-studied. Four categories of clergy stressors have been proposed: vocational stressors (inadequate pay, unrealistic time demands, relocation); intrapersonal stressors (emotional exhaustion, 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) (Rowatt, 2001). The antecedents of clergy stress have also been proposed to be in four areas: personal criticism, boundary ambiguity, presumptive expectations, and family criticism (Lee & Iverson-Gilbert, 2003). Population studies indicating the degree and extent of clergy stress are missing. However, researchers have begun to study a corollary of stress, which is occupation burnout (Maslach, 1982), among clergy. Certainly, more needs to be studied in terms of the causes of clergy burnout and means of prevention, and fortunately that work is underway.

This special issue on clergy health strives to cover a range of different kinds of health, including emotional well-being, work-related psychological health, sexual health, and physical health. The issue also focuses on health interventions by examining the kinds of health interventions clergy desire and the

acceptability to clergy of having health interventions in their church to improve the health of both clergy and congregants. We were intentionally holistic in our definition of clergy health, just as clergy themselves are (Proeschold-Bell et al., 2009).

The process of soliciting manuscripts made us acutely aware of additional research gaps in clergy health. We were unable to find any published research on the health of Jewish rabbis or Muslim imams. There is also little international research on clergy health. We could benefit from clergy health research focused on sub-groups of clergy, such as women and African-American clergy. Finally, there are many interesting research questions that the study of clergy health can help us answer, including, "What is the role of spirituality in successful health interventions?" and "How does the health of the person in the pulpit affect the health of the people in pews, and vice versa?"

We hope this special issue will entice researchers to examine clergy health. You would be hard-pressed to find people more dedicated to their vocation than clergy, more intentional about their formation as human beings, or more thoughtful about their interactions with most people in their lives. Now it is our turn to dedicate ourselves to them.

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