Attitudes and behaviors that differentiate clergy with positive mental health from those with burnout

AUTHORS

Andrew D. Case
Department of Psychological Science
University of North Carolina at Charlotte

Corey L. M. Keyes
Department of Sociology
Emory University

Katie F. Huffman
Duke Divinity School
Duke University

Kelli Sittser
Duke Divinity School
Duke University

Amanda Wallace
Duke Divinity School
Duke University

Prasana Khatiwoda
Duke Global Health Institute
Duke University

Heather E. Parnell
Duke Center for Health Policy & Inequalities Research
Duke University

Rae Jean Proeschold-Bell*
Duke Global Health Institute, Duke Center for Health Policy & Inequalities Research
Duke University

Corresponding author:
Rae Jean Proeschold-Bell, PhD
Duke Global Health Institute, Duke Center for Health Policy & Inequalities Research
Box 90392
Durham, NC 27708-0392
Tel: (919) 613-5442
Fax: (919) 613-5466
Rae.jean@duke.edu

Abstract

Clergy provide significant support to their congregants, sometimes at a cost to their mental health. Identifying the factors that enable clergy to flourish in the face of such occupational stressors can inform prevention and intervention efforts to support their well-being. In particular, more research is needed on positive mental health and not only mental health problems. We conducted interviews with 52 clergy to understand the behaviors and attitudes associated with positive mental health in this population. Our consensual grounded theory analytic approach yielded five factors that appear to distinguish clergy with better versus worse mental health. They were: (1) being intentional about health; (2) a "participating in God's work" orientation to ministry; (3) boundary-setting; (4) lack of boundaries; and (5) ongoing stressors. These findings point to concrete steps that can be taken by clergy and those who care about them to promote their well-being.

KEYWORDS

Burnout, clergy, occupational health, positive mental health, prevention

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Introduction

Clergy support their congregants through performing six central roles [1, 2]. They provide counseling to congregants, often being the first to respond in a time of crisis [3, 4]. In fact, clergy are the first support sought by nearly one-quarter of all people in the United States (US) seeking help for a serious mental illness [5]. In addition, clergy inspire congregants through preaching. They help make meaning through administering sacraments and conducting rites of passage. Clergy mentor congregants and provide religious teaching, and they impact the larger community through community organizing. In addition to these roles that directly affect congregants and the community, clergy also perform administrative tasks, such as supervising church staff and managing the congregation's finances.

While a variety of people benefit from the work clergy do, clergy work is difficult. The combination of responsibilities clergy hold creates a workday that is busy, fragmented, and varied, with little predictability [6]. These complex days sometimes are full of emotion; compared to the average person in the US, Episcopal priests report experiencing more positive, as well as more negative, emotions [7]. Clergy willingly experience these emotions and engage in diverse work. This is because prior to becoming clergy, they experienced a sacred call to ministry which likely was a combination of: a personal sense of wanting to serve God, having this sense affirmed by a religious leader, and believing that they have the skills to serve as a clergy person [8].

Despite their devotion, clergy work carries with it the risk of burnout and depression. Studies have found that, compared to national US burnout scores, clergy scores qualify them for moderate levels of emotional exhaustion, depersonalization, and low feelings of personal accomplishment [9]. Their burnout rates are similar to those reported by social workers and teachers, which the authors suggest may be due to similarities across these professions in role complexity and ambiguity, role conflict, sustaining complex and long-term relationships with people, and not always seeing the immediate results of their work [9]. In terms of depression, studies have found depression rates in Catholic and Protestant clergy ranging from 9% to 20% [10, 11, 12], in each case higher than national depression rates. Workers experiencing burnout are less effective at work [13, 14], and people experiencing depression are more likely to miss work and be less productive while at work [15]. It is therefore important to prevent burnout and depression in clergy, for both the benefit of clergy themselves and for the congregants and communities they serve.

Few intervention studies that address depression and burnout in clergy have been published. In one intervention, called Spirited Life, researchers were unable to improve clergy depression

rates, possibly because they were trying to identify and treat existing cases of depression [16]. A different approach would be to prevent depression in the first place, and a national strategy to prevent depression has been proposed based on the relationship between depression and *positive* mental health [17]. Although people commonly think of mental health in terms of mental health problems, there is another dimension to mental health which is the presence of positive aspects. Positive mental health has been conceptualized as: 1) the presence of positive emotions; 2) good psychological functioning in terms of having a sense of purpose in life, feeling positively towards others, and accepting oneself; and 3) good social functioning in terms of a sense of belonging, feeling part of society, and having something to offer the world [18].

A measure of positive mental health called the Mental Health Continuum-Short Form has been used with the same individuals in a nationally representative US sample in 1995 and again in 2005. Responses to this measure allow people to be classified as having flourishing, moderate, or languishing mental health. Compared to people who qualified as having moderate mental health in both 1995 and 2005, people who were flourishing in both 1995 and 2005 were three times less likely to have a mental illness in 2005 [19]. Compared to people who stayed flourishing, people who stayed languishing or moved from better mental health to languishing were seven times more likely to have a mental illness in 2005.

While intuitively it makes sense that positive emotions and better functioning prevent depression, the underlying process has been explained and tested using Broaden-and-Build theory [20]. The process begins with positive emotions that broaden one's thinking, making people be open to new ideas, be better problem solvers, and be more sociable, as demonstrated in numerous laboratory studies [21]. Compared to those who have low or moderate levels of positive emotions, having more positive emotions on a daily basis provides an advantage in the form of broadened thinking. The behaviors that come from a broadened mind build up one's resources in the form of more skills, more friends, and even a better job and higher pay [22]. Then, when faced with a difficulty, these resources can be drawn on to cope – and avoid depression.

Motivated to prevent depression in clergy, we sought to understand positive mental health in clergy. We were inspired by a study by Catalino and Fredrickson [23] in which participants were divided into flourishing and non-flourishing groups and factors related to flourishing were identified. In our study, we sought to identify differences between pastors with flourishing mental health versus those with languishing mental health and burnout. In so doing, we hoped to go beyond laboratory studies to identify the various factors related to why some clergy have flourishing mental health and others do not under real-world conditions and to offer practical suggestions for clergy to sustain positive mental health while performing meaningful but difficult work.

Methods

Participants

Participants in this study were United Methodist Church (UMC) clergy who belonged to the North Carolina or Western North Carolina Annual Conference and who participated in the Spirited Life intervention study. The Spirited Life study tested a two-year holistic health and wellness intervention. Clergy were recruited regardless of mental health status. A total of 1,114

UMC clergy enrolled in 2010. All participants received the intervention. The evaluation included surveys administered approximately every six months for four and a half years [24]. Participants for the current study were drawn from the pool of 592 clergy who completed a Spirited Life survey in spring 2014, and indicated willingness to be contacted for future studies. The available pool of clergy shrank to 99 after taking into account inclusion and exclusion criteria that we applied to assist with a separate study. These criteria were being appointed to a church, being either an elder or local pastor (i.e., not a deacon or student pastor) in the United Methodist Church, and if a local pastor, currently serving at least one rural church and/or one small church (defined as 50 or fewer attendants per week). The criteria additionally included having served in ministry a specific number of years (either 3-7, 10-18, or 23-40 years).

The Spirited Life survey included four measures that we used to determine study eligibility based on mental health inclusion/exclusion criteria. The Mental Health Continuum-Short Form (MHC-SF) is a 14-item scale that measures emotional well-being and psychological and social functioning using items such as, "During the past month, how often did you feel…" "happy,"; and "that you had something important to contribute to society" [25]. We added two items that we created: "How often did you feel…" "joyful" and "content." We chose this measure because it has strong predictive validity; it is predictive of consequential outcomes such as cardiovascular disease, all-cause mortality, acute health care service use, prescription use, limitations in activities of daily living, and missed work [26, 18, 17, 27]. It has scoring procedures to categorize respondents as having flourishing mental health, moderate mental health, or languishing mental health. However, in our sample (N=99), 64% of eligible clergy (n=63) qualified for flourishing mental health and only 2% (n=2) qualified for languishing mental health. Using the MHC-SF alone, we were not able to identify enough clergy with languishing mental health from which to recruit, and, with such a high percentage of clergy qualifying for flourishing mental health, we sought other means to identify clergy with the highest positive mental health. We categorized clergy who responded "every day" or "almost every day" to all items as having flourishing mental health (FMH).

A second measure used the 22-item human services version of the Maslach Burnout Inventory (MBI) [28]. The MBI measures three subscales: emotional exhaustion, feelings of cynicism and detachment, and beliefs of ineffectiveness and lack of accomplishment. Based on the MBI manual [28], we classified participants as "burned out" if they scored within the highest tertile of scores in the US population on any one of the three subscales. For the current study, we categorized clergy as having "low mental health and burnout" (LMH-B) if they qualified for burnout on at least one of the three MBI subdomains and additionally had scores in the bottom tertile on the emotional subdomain and the psychological/social subdomain of the MHC-SF.

A third measure was the Patient Health Questionnaire-8 (PHQ-8), consisting of eight items on the frequency of depression symptoms during the past two weeks, with scores ranging from 0 to 24 [29]. We excluded participants whose survey responses suggested high symptoms for depression (scores of 10 or higher on the PHQ-8). The final measure was the three-item Alcohol Use Disorder Identification Test-Consumption (AUDIT-C), which screens for heavy drinking and active alcohol abuse [30]. We excluded participants with scores of 4 or higher for males and 3 or higher for females. By excluding those participants (n=27) with high depression or alcohol abuse scores, we followed Catalino's lead [23] and ensured we could focus on

positive mental health versus low mental health in the absence of mitigating factors such as depression or alcohol abuse.

Procedure

After identifying a pool of clergy with flourishing mental health and low mental health with burnout (N=99), we used email to invite an initial 55 to participate in the study. We did not invite them all at once because we only wanted to interview approximately 50. Once we determined we would need to invite more than the initial 55, we invited additional clergy in small batches (8, then 9, then 26) until we ultimately recruited 18 low mental health with burnout and 34 flourishing mental health participants. We provided clergy who indicated interest a web link to an online consent form, and we scheduled an interview with clergy who consented. Participants were given the option of doing the interview using web video (via *Cisco WebEx*; 54% chose this method) or an in-person interview at a venue of their choosing. Prior to each interview, we administered a survey that repeated the five measures described above, because up to eight months had elapsed since the Spirited Life survey. We audiorecorded the interviews, which had a duration of 38-126 minutes, and transcribed them.

Data Analysis Plan

A team of six people analyzed the data. Three of the people were highly knowledgeable about the work of pastors and three were researchers with some familiarity of pastoral work. The first author was the lead analyst; he has substantial experience in qualitative analysis and provided training to the other analysts.

We used a consensual, grounded-theory approach to analyze the transcripts. This approach was informed by Constructivist Grounded Theory (CGT) [31] and Consensual Qualitative Research (CQR) [32]. CGT emphasizes coding, comparisons, and abstractions (i.e., moving from describing to a working theory) to arrive at a theory explaining a phenomenon, while CQR details a team-based approach to data analysis. Our approach consisted of four distinct phases that allowed for in-depth analysis of each transcript and groups of transcripts, as well as comparisons across transcripts and groups of transcripts. NVivo v10 software was used to assist the analysis.

Phase 1: Codebook development. The purpose of the first phase of analysis was to create a codebook that would guide subsequent analysis. A total of six transcripts (12%) representative of pastors across the FMH and LMH-B mental health status groups was selected. Analysts were blinded to the mental health status of the participants. Each analyst conducted "open coding" on each transcript, whereby they identified units of meaning and assigned them a representative word or phrase (i.e., code). The analysts then met as a group to agree on code labels and to delineate properties for these codes. The resulting codebook included eight broad categories of codes and more than 200 codes.

Phase 2: Individual coding**.** Using the codebook derived in the prior phase, each analyst conducted "focused coding" on a subset of the remaining transcripts. That is, they classified the data using the coding schemes in the codebook. Additionally, they created two memos for each transcript: a summary memo that highlighted themes in the data that were especially important, and an interpretive memo that recorded the analysts' emerging insights.

Phase 3: Code refinement**.** During individual coding, analysts met once every other week to discuss any difficulties in coding and to elaborate on properties of codes.

Phase 4: Comparative analysis**.** In the final phase, analysts conducted analyses within mental health groups and across them. At this point, analysts were informed of the mental health status of participants. The team began with the FMH group, identifying themes on attitudes and behaviors that were common to this group and that appeared to support positive mental health. Next, transcripts from the LMH-B group were analyzed to see how often those themes were present. Then, the transcripts of the LMH-B group were analyzed to identify themes unique to those transcripts that may represent barriers to flourishing.

Quality assurance in analysis and findings. We ensured the quality of the analysis and our findings through two procedures. First, we built in an audit process at Phase 2 of the analysis. Specifically, the lead analyst reviewed and provided written feedback on 25% of the coding and memo-ing completed by the other analysts. Second, for the analysis of the LMH-B group in Phase 4, we conducted a negative case analysis; each transcript was analyzed by two analysts to reduce the likelihood of overlooking flourishing factors in this group. In this way, we actively sought cases that ran contrary to our emerging findings.

Follow-up interviews**.** Once themes were determined, we conducted follow-up interviews with a subset of 11 flourishing participants to get practical examples of how they promoted their mental health, which is consistent with the real-world focus of this study. In addition to highlighting themes from the data, we included the suggestions and recommendations of flourishing clergy for enacting health-promoting behaviors and attitudes.

The Duke University Arts and Sciences Institutional Review Board approved all procedures.

Results

In total, we recruited 52 participants: 34 FMH and 18 LMH-B participants. Participants' mean age was 55 years. Twenty (38%) were female, 46 (88%) were married, 47 (90%) were White, and 4 (8%) were African-American. For ministry length, 11 (21%) had served 3-7 years, 24 (46%) had served 10-18 years, and 17 (33%) had served 25-35 years. Participants primarily reported serving medium-sized churches, i.e., attended by 51-350 congregants at weekly worship (32 participants or 62%), with 10 (19%) serving small (50 or fewer congregants at weekly worship) and 10 (19%) serving large churches (more than 350 congregants at weekly worship). Eleven participants (21%) were appointed to more than one church.

Through our analysis, we identified five themes that differed between FMH and LMH-B participants. As depicted in Table 1, these themes differ by mental health status group in the frequency to which they were endorsed. Although reporting theme frequencies is somewhat atypical of qualitative research, we include this information to give a sense of how common the themes are for each group.

Theme 1: Being Intentional about Health and Well-being Promotion

FMH participants more often recognized the importance of engaging in health and well-being-promoting practices and reported routinely engaging in these practices. In fact, many stated that they engaged in such practices daily. For example, some reported practices were physical activities such as exercise; spiritual practices (prayer, Bible reading); relational activities (spending time with friends and families); and leisurely activities (e.g., hobbies like fishing or hiking). One participant stated,"I learned pretty early on that personal care was essential and I just built it into my daily routine, and I'm pretty habitual and methodical about it now."

To enact these healthy behaviors, FMH participants reported having daily routines, but indicated that their days often did not unfold as intended and that they had to be flexible within any given day to make sure they engaged in the activity at some point. Interestingly, FMH participants planned to be flexible; in advance, they thought of ways to accomplish their healthy behaviors even if disrupted. Two other intentional health strategies that FMH participants reported were finding a kind of exercise that they liked (or at least could get used to) and incorporating a favorite healthy behavior into their ministry work. For example, one pastor who liked to run, organized a 5k run for the church. In addition, some FMH participants recommended strategies to prevent weight gain. Table 2 describes some strategies in the words of the participants.

Theme 2: Participating in God's Work and Emphasizing Process over Outcome

FMH participants were more likely than those belonging to the LMH-B group to describe an orientation to ministry in which ministry was seen as "God's work" and they were merely participants in that work. The following are quotes from two different participants:

It's a matter of setting yourself aside and allowing God to work through us (clergy). So [my] hopes and dreams were to get to the point where I could be a pastor of a church, and be able to allow God to work through me.

I always tell them we need to do what God is blessing and not ask God to bless what we're doing, and there it is in a nutshell. I think I should ask them to put that on my tombstone. The important thing is if this is something that God wants us to do, things will work and fall into place.

FMH participants described this orientation to ministry as one in which humility appeared important; they saw their responsibility as ministers to allow God to act through them. Consequently, they recognized the need to continually surrender their ministry—its vision, goals, and strategies—to God.

Perhaps as a consequence of this orientation to ministry, adherents often emphasized the process of ministry over its results. These participants believed working in concert with God was more important than achieving a desired result for ministry efforts. The de-emphasis on outcomes seemed to at least be partially based in the expectations that God's work does not always have an immediate and recognizable outcome and sometimes God's intended outcome may not be what we initially envision.

When asked how they keep God and the process of ministry at the center of their work, FMH participants indicated that they were always discerning:

So in a practical day-to-day way what does that look like? I think it begins in prayer and ends in prayer, following the promptings of the Holy Spirit. I can't express how many times in my life … both just as a person in Christ, but also as a pastor in Christ, that I felt like the Holy Spirit was saying you need to go speak to this person or you need to go visit this person or … whatever. And then without fail, if I'm obedient to that voice …, it becomes clear why I need to do that.

Theme 3: Having a Bounded Approach to Ministry

A higher percentage of participants with FMH evidenced an orientation to ministry in which they proactively created boundaries between their work life and home/family life. According to participants, creating these boundaries allowed them to fulfill family obligations, as well as to engage in health- and well-being-promoting practices such as exercise, spending time with friends and family, and pursuing hobbies. One participant passionately noted how important it was for her to secure a consistent day off:

I've learned that you can't do everything in one day and you can't be everywhere at the same time. *I need a day!* I tell my Pastor Parish Relations Committee chairperson, 'This is my day. Anything that arises, you're going to take it down…I need a day off.'

Participants reported erecting boundaries through a number of means. Boundaries were often negotiated with congregant committees. They took the form of weekly Sabbaths, annual vacation time, sabbaticals, and fixed office hours. Other participants reported setting boundaries by not taking calls at home after a certain time or delineating their roles and responsibilities from those of lay leaders and staff. Participants indicated that they have relative control over their calendars if they are proactive, and that communication with congregant leaders is essential. Table 3 provides concrete suggestions and quotes.

Theme 4: Having an Un-Bounded Approach to Ministry

While more FMH participants approached ministry with boundaries, more LMH-B participants approached ministry with few or porous boundaries between work and other life domains. Participants who had this approach mentioned that a lack of boundaries resulted in their taking work home and experiencing difficulty "disconnecting" from work and being present for other aspects of life. In the words of one participant:

My life is more likely out of balance….It looks like working a lot, taking work home with me. Even when I'm at home, I'm sitting on the couch doing some paperwork on the computer… I think one of the huge difficulties is turning it off, setting boundaries so that the other things in my life are addressed appropriately, like family and relationships.

While this participant attributed a lack of boundaries between her work and home life to a personal inability or shortcoming on her part to establish boundaries, other participants pointed to demands placed on them by their congregants as the primary reason for their challenges. Interestingly, at least one participant stated that they enjoyed being available to congregants continuously or being engaged in ministry for long periods of time without breaks. Thus, clergy who practice this approach might experience some difficulty establishing boundaries due to demands placed on them by parishioners or discomfort requesting boundaries from congregants. Alternatively, an unbounded orientation to ministry might indicate a personal preference for how a particular clergy person wishes to work.

Theme 5: Ongoing Stressors

We completed a focused ad-hoc analysis on LMH-B participants to understand how to characterize challenges unique to this group. Our analyses revealed that nearly all mentioned experiencing one or more ongoing stressors that they believed were currently undermining

their mental health. One such stressor was a lack of self-acceptance, defined in this study as "having a positive attitude toward yourself and your personality, while being able to acknowledge and accept current or past negative aspects of yourself." In the final section of the interview, participants were given a list of factors known to be associated with positive well-being and asked which two were most present and which two were most absent over the past two months. A higher percentage of LMH-B participants compared to FMH participants reported lacking self-acceptance. Several participants acknowledged that they had high expectations for themselves or held negative views of themselves, and that this prevented them from being self-accepting and created difficulty in their work. One participant said:

I think that (lack of self-acceptance) has to do with depression. I've been under medication for depression for 25 years…I've probably been depressed all my life. And so that is a struggle, and that's something that I've had to deal with… If I can't accept myself, how can I accept other people?

Other ongoing stressors reported by participants with low mental health and burnout include a history of psychiatric illness (e.g., depression), chronic physical illness (e.g. rheumatoid arthritis), financial strain, being a caretaker to an ill spouse or relative, and experiencing difficulty forging social connections due to being new to the area or being too busy with their ministry. In addition, some indicated a suboptimal fit between them and their ministry appointment. Specifically, they expressed dissatisfaction with how frequently they had to engage with demanding congregants or in ministerial tasks that they disliked (e.g., administrative duties).

Discussion

Five themes emerged that seemed to distinguish clergy participants with flourishing versus low mental health. Our analysis process allowed us not only to list behaviors and attitudes that participants were aware of, but also to identify those that differentiated the two groups and of which participants may have been unaware. Some themes were unexpected. For example, we did not anticipate finding that flourishing participants align their work with God and emphasize process over short-term outcomes. Other themes were more obvious, such as being intentional about one's health and well-being. Even those, however, provide useful data that flourishing participants were able to enact healthy behaviors even with the unpredictability of ministry life. For example, one participant who was committed to exercising reported that they managed to exercise regularly by proactively identifying multiple kinds of exercise and multiple times and places where exercise might be possible. They described having a regular exercise plan, but also having a back-up plan to enact in the case of disruptions and shifting their plans within a specific day. Having an intentional but flexible approach to exercise might be an effective means of clergy engaging in this health behavior despite having considerable and unpredictable demands on their time. It should be noted that exercise itself is strongly linked to better mental health. Exercise can prevent depression; it is also comparable to taking antidepressant medication in achieving depression remission [33]. Physical activity is highly recommended for

everyone and is especially relevant for clergy, given their high rates of depression and moderate rates of burnout.

One of the key distinctions between flourishing and low mental health with burnout participants was having boundaries between ministry and personal life. The organizations and management literature has moved from assuming that spillover from work life into personal life and vice versa is necessarily bad for one's mental health [34]. Many studies have found such spillover to be positive for mental health [35]. However, the current study provides some evidence for clergy that stricter work-life boundaries are beneficial to their positive mental health, although it is possible that the directional influence is instead that clergy with positive mental health are more likely to enact work-life boundaries. Previous studies have reported that not only are clergy expected to be available around the clock, but that clergy themselves often see their ministry as one of constantly serving others [36]. It may be that the sacred nature of ministry work pulls for constant availability. Kenneth Pargament [37] has proposed sanctification theory, which states that when work is sacred, one will exert extra effort toward it, fiercely protect it, and experience devastation if one fails. It is possible that clergy resist setting work-life boundaries because they do not want to fail, and yet engaging in ministry is challenging and rarely provides concrete feedback of success. Clergy supervisors could help clergy by normalizing for them the challenges they face and, when true, assure them that they are doing enough.

Clergy supervisors and lay leaders can also support clergy in establishing work-life boundaries. Religious institutions are structured differently, and so the people needed to support the clergy person may differ. In the UMC, pastors report to personnel committees made up of the church's lay leaders. To assist with work-life boundaries, pastors and personnel committee members should be in close communication. First, they should get clear on expectations of the pastor, which will assist the pastor in knowing what to prioritize, because otherwise there is simply too much work to allow for any life outside of the church. Second, pastors should communicate about their time off by giving advance notice of vacation and noting their Sabbath day on shared calendars or possibly in email signature lines; doing so helps others avoid interrupting clergy time off with non-urgent requests. Third, when disagreements between clergy and congregants occur, these should be discussed promptly, directly, and, ideally, with kindness. Direct communication is good for everyone to resolve the problem and to prevent unnecessary negative emotions for pastors and laity alike.

In this study, flourishing participants, but not participants with low mental health and burnout, discussed focusing on the process of working with God and trying not to tie their feelings to short-term outcomes. Working in line with your mission has been promoted by businesses [38]; it is interesting to see this same idea surface with clergy and their higher calling. At the most important level of their work, clergy answer to God, who does not give them a written annual review but who is deeply personal and important to them. At other levels of their work, clergy report to their congregations' personnel committees, which do perform annual reviews of their work; clergy who focus on the daily opinions that congregants have of them may experience lower levels of positive mental health as a result.

Participants with low mental health and burnout often reported experiencing ongoing stressors such as caregiving for sick family members, having a history of depression, or being chronically ill that negatively affected their mental health. Clergy supervisors might consider

how best to support clergy in these situations, possibly through referring them to available resources or avoiding assigning clergy to difficult congregations if they are at a difficult point in their personal life. Clergy supervisors may also identify and try to improve any hurtful congregational climates.

This study has several limitations. Although this study allowed for themes to emerge that we could not have anticipated and included on a survey, we interviewed only 52 participants in total, only 18 of whom had low mental health. Thus, our findings need to be validated with a larger sample size. In addition, all of our participants were church-appointed pastors from the United Methodist Church in North Carolina. Although substantial similarity across Catholic and Protestant denominations and across countries has been found on clergy tasks [6, 12], caution should be exercised when generalizing this study's findings.

This study also has several strengths. Our study participants were involved in a holistic health intervention study in which they received support to identify and work on health goals; it is possible that the intervention led to ideas that would not have been considered otherwise, and that participants had been engaged in enacting these ideas long enough to influence flourishing versus low mental health status. In addition, the study's qualitative analysis consisted of multiple phases with multiple people to avoid in-group thinking. Finally, once themes were determined, we conducted follow-up interviews with flourishing participants to get practical examples, which is consistent with this study's real-world focus.

In the future, researchers might use surveys with larger numbers of diverse clergy to assess whether the themes identified here predict positive mental health status. Even then, there could only be a correlation between these themes and positive mental health. A more definitive test requires intervention research. For example, clergy could be randomly assigned to study conditions such as enacting work-life boundaries themselves (e.g., not taking phone calls during dinner) or having their supervisors encourage them (e.g., encourage conference-wide Sabbath-keeping). Alternatively, for working in alignment with God, clergy might turn to centuries-old spiritual practices such as the Catholic Daily Examen, in which people use prayer to identify missed opportunities that God may be setting before them and make a plan to act accordingly (c.f., www. ignatianspirituality. com; [39]. Rigorous intervention studies would enable the development of effective clergy-specific interventions.

Ultimately, it is essential that clergy proactively attend to their mental and physical well-being. It is widely accepted that healthy leaders benefit the people they serve, and that is likely the case for clergy, too [40]. We suggest that high positive mental health is particularly important for leaders, based on the empirical literature linking positive emotions to seeing the big picture, problem-solving, generating creative ideas, and working with a variety of people [21]. The findings offered here should bring hope to very busy clergy that they, too, can enact behaviors that promote positive mental health. We wish clergy well as they serve their congregants and ideally model healthy behaviors. Clergy or not, we can all take the lessons of this study to heart.

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References

1 Blizzard, S. W. (1956). The minister's dilemma. Christian Century, 73, 508–510.
2. Milstein, G., Kennedy, G. J., Bruce, M. L., Flannelly, K., Chelchowski, N., & Bone, L. (2005). The clergy's role in reducing stigma: A bilingual study of elder patients' views. World Psychiatry, 4 (S1), 26–32.
3. Bohnert, A. S. B., Perron, B. E., Jarman, C. N., Vaughn, M. G., Chatters, L. M., & Taylor, R. J. (2010). Use of clergy services among individuals seeking treatment for alcohol use problems. American Journal of Addictions, 19, 345–351. doi:1O.llllj.15210391.2010.00050.x
4. Chatters, L. M., Mattis, J. S., Woodward, A. T., Taylor, R. J., Neighbors, H. W., & Grayman, N. A. (2011). Use of ministers for a serious personal problem among African Americans: Findings from the National Survey of American life. American Journal of Orthopsychiatry, 81 (1), 118–127. doi:10.1111/j.1939-0025.2010.01079.x
5. Wang, P. S., Berglund, P. A., & Kessler, R. C. (2003). Patterns and correlates of contacting clergy for mental disorders in the United States. Health Services Research, 38 (2), 647–673. doi:10.1111/1475-6773.00138
6. Kuhne, G. W., & Donaldson, J. F. (1995). Balancing ministry and management: An exploratory study of pastoral work activities. Review of Religious Research, 37 (2), 147–163. doi:10.2307/3512398
7. Stewart-Sicking, J. A. (2012). Subjective well-being among Episcopal priests: Predictors and comparisons to non-clinical norms. Journal of Prevention & Intervention in the Community, 40 (3), 180–193. doi:10.1080/10852352.2012.680408
8. Campbell, D. M. (1994). The call to ordained ministry who will go for us?: An invitation to ordained ministry (pp. 26–59). Nashville, TN: Abingdon Press.
9. Adams, C., Hough, H., Proeschold-Bell, R. J., Yao, J., & Kolkin, M. (2017). Clergy burnout: A comparison study with other helping professions. Pastoral Psychology, 66 (2), 147–175. doi:10.1007/s11089-016-0722-4
10. Knox, S., Virginia, S. G., & Lombardo, J. (2002). Depression and anxiety in Roman Catholic secular clergy. Pastoral Psychology, 50 (5), 345–358.
11. Knox, S., Virginia, S. G., Thull, J., & Lombardo, J. P. (2005). Depression and contributors to vocational satisfaction in Roman Catholic secular clergy. Pastoral Psychology, 54 (2), 139–153. doi:10.1007/s11089-005-6199-1
12. Proeschold-Bell, R. J., Miles, A., Toth, M., Adams, C., Smith, B. W., & Toole, D. (2013). Using effort-reward imbalance theory to understand high rates of depression and anxiety among clergy. The Journal of Primary Prevention, 34 (6), 439–453. doi:10.1007/s10935013-0321-4
13. Hall, T. W. (1997). The personal functioning of pastors: A review of empirical research with implications for the care of pastors. Journal of Psychology and Theology, 25(2), 240–253. doi:10.1177/009164719702500208

14. Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. Annual Review of Psychology, 52, 397–422. doi:10.1146/annurev.psych.52.1.397
15. Beck, A., Crain, A. L., Solberg, L. I., Un€utzer, J., Glasgow, R. E., Maciosek, M. V., & Whitebird, R. (2011). Severity of depression and magnitude of productivity loss. Annals of Family Medicine, 9 (4), 305–311. doi:10.1370/afm.1260
16. Proeschold-Bell, R. J., Turner, E. L., Bennett, G. G., Yao, J., Li, X.-F., Eagle, D. E., … Toole, D. C. (2017). A 2-year holistic health and stress intervention: Results of an RCT in clergy. American Journal of Preventive Medicine, 53 (3), 290–299. doi:10.1016/ j.ampere.2017.04.009
17. Keyes, C. L. M. (2007). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. American Psychologist, 62 (2), 95–108. doi:10.1037/0003-066X.62.2.95
18. Keyes, C. L. M. (2005). Mental illness and/or mental health? Investigating axioms of the complete state model of health. Journal of Consulting and Clinical Psychology, 73 (3), 539–548. doi:10.1037/0022-006X.73.3.539
19. Keyes, C. L. M., Dhingra, S. S., & Simoes, E. J. (2010). Change in level of positive mental health as a predictor of future risk of mental illness. American Journal of Public Health, 100 (12), 2366–2371. doi:10.2105/AJPH.2010.192245
20. Fredrickson, B. L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. American Psychologist, 56 (3), 218. doi: 10.1037//0003-066X.56.3.218
21. Fredrickson, B. L. (2013). Positive emotions broaden and build. In P. Devine & A. Plant (Eds.), Advances in Experimental Social Psychology (Vol. 47, pp. 1–53). San Diego, CA: Elsevier.
22. Lyubomirsky, S., King, L., & Diener, E. (2005). The benefits of frequent positive affect: Does happiness lead to success? Psychological Bulletin, 131 (6), 803–855. doi:10.1037/ 0033-2909.131.6.803
23. Catalino, L. I., & Fredrickson, B. L. (2011). A Tuesday in the life of a flourisher: The role of positive emotional reactivity in optimal mental health. Emotion, 11 (4), 938–950. doi: 10.1037/a0024889
24. Proeschold-Bell, R. J., Swift, R., Moore, H. E., Bennett, G., Li, X.-F., Blouin, R., … Toole, D. (2013). Use of a randomized multiple baseline design: Rationale and design of the Spirited Life holistic health intervention study. Contemporary Clinical Trials, 35 (2), 138–152. doi:10.1016/j.cct.2013.05.005
25. Keyes, C. L. M. (2002). The mental health continuum: From languishing to flourishing in life. Journal of Health and Social Behavior, 43 (2), 207–222. doi:10.2307/3090197
26. Keyes, C. L. M. (2004). The nexus of cardiovascular disease and depression revisited: The complete mental health perspective and the moderating role of age and gender. Aging & Mental Health, 8 (3), 266–274. doi:10.1080/13607860410001669804
27. Keyes, C. L. M., & Simoes, E. J. (2012). To flourish or not: Positive mental health and allcause mortality. American Journal of Public Health, 102 (11), 2164–2172. doi:10.2105/ AJPH.2012.300918
28. Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). Maslach Burnout Inventory Manual (Third ed.). Mountain View, CA: CPP, Inc.

29. Kroenke, K., Strine, T. W., Spitzer, R. L., Williams, J. B. W., Berry, J. T., & Mokdad, A. H. (2009). The PHQ-8 as a measure of current depression in the general population. Journal of Affective Disorders, 114 (1–3), 163–173. doi:10.1016/j.jad.2008.06.026
30. Bush, K., Kivlahan, D. R., McDonell, M. B., Fihn, S. D., & Bradley, K., for the Ambulatory Care Quality Improvement Project (ACQUIP). (1998). The AUDIT Alcohol Consumption Questions (AUDIT-C). Archives of Internal Medicine, 158 (16), 1789–1795. doi:10.1001/archinte.158.16.1789
31. Charmaz, K. (2006). Constructing grounded theory. Thousand Oaks, CA: Sage.
32. Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. The Counseling Psychologist, 25 (4), 517–572. doi:10.1177/0011000097254001
33. Hoffman, B. M., Babyak, M. A., Craighead, W. E., Sherwood, A., Doraiswamy, P. M., Coons, M. J., & Blumenthal, J. A. (2011). Exercise and pharmacotherapy in patients with major depression. Psychosomatic Medicine, 73 (2), 127–133. doi:10.1097/ PSY.0b013e31820433a5
34. Nitzsche, A., Pfaff, H., Jung, J., & Driller, E. (2013). Work–life balance culture, work–home interaction, and emotional exhaustion. Journal of Occupational and Environmental Medicine, 55 (1), 67–73. doi:10.1097/JOM.0b013e31826eefb1
35. Greenhaus, J. H., & Powell, G. N. (2006). When work and family are allies: A theory of work-family enrichment. Academy of Management Review, 31(1), 72–92. doi:10.5465/amr.2006.19379625
36. Proeschold-Bell, R. J., LeGrand, S., James, J., Wallace, A., Adams, C., & Toole, D. (2011). A theoretical model of the holistic health of United Methodist clergy. Journal of Religion and Health, 50 (3), 700–720. doi:10.1007/s10943-009-9250-1
37. Pargament, K. I., & Mahoney, A. (2005). Theory: Sacred matters: Sanctification as a vital topic for the psychology of religion. International Journal for the Psychology of Religion, 15 (3), 179–198. doi:10.1207/s15327582ijpr1503_1
38. Kantabutra, S., & Avery, G. C. (2010). The power of vision: Statements that resonate. Journal of Business Strategy, 31 (1), 37–45. doi:10.1108/02756661011012769
39. Puhl, L. J. (1951). Translation: The spiritual exercises of St. Ignatius of Loyola. Retrieved from http://spex.ignatianspirituality.com/SpiritualExercises/Puhl.
40. Boyatzis, R. E., Brizz, T., & Godwin, L. N. (2011). The effect of religious leaders' emotional and social competencies on improving parish vibrancy. Journal of Leadership and Organizational Studies, 18 (2), 192–206. doi:10.1177/1548051810369676

Table 1
Percentage of participants by clergy group with narratives consistent with theme

Theme	Flourishing mental health (N=34), %(n)	Low mental health AND high burnout (N=18), %(n)
1. Being Intentional About Health and Well-being-Promotion	94% (32)	56% (10)
2. Participating in God's Work and Emphasizing Process over Outcome	56% (19)	22% (4)
3. Having a Bounded Approach to Ministry	65% (22)	33% (6)
4. Having an Un-Bounded Approach to Ministry	6% (2)	67% (12)
5. Subset of Theme 5: Having Difficulty Accepting Oneself*	9% (3)	39% (7)

*Note. Theme 5, Ongoing Stressors, emerged during a posthoc analysis and its broad nature made it difficult to characterize and count every stressor by mental health status. However, one stressor, difficulty with self-acceptance, was more specific and allowed for counting.

Table 2
Suggestions from flourishing participants on how to enact healthy behaviors

Participant suggestions	**Participant quotes**
You don't have to sample every dish in the potluck line. Let people know that you will sample dishes from different congregants each potluck, because you're watching your weight.	"There is something to accepting people's hospitality with them in their homes and sharing their meals, but that doesn't mean you've got to eat and eat and eat. . . . A lot of pastors that are overweight or even obese, and so if you're . . . not yet there, then it's a whole lot easier to adopt practices now that will lead you to health than it is to get it out of hand and then try to rein it back in."
Find a type of exercise you like and be flexible in how you work it into your day. Walking is a flexible form of exercise that also can be done as a group, such as pedometer programs in which you can meet a goal together (e.g., take enough steps to walk to Jerusalem) or compete against each other.	"So this is the very best thing happening to me lately. . . I sync this thing [pedometer] every night—every night. And it enables me to engage other people and it pushes me out of my house on cold evenings to walk four or five miles. It's incredible. And I'm probably healthier from a mental health perspective now than I have been in a long, long time because of that exercise program." "I even tell people the reason I do this is for my mental and physical and spiritual sanity. I want to be a great pastor for you."
Combine interests with sermons or ministry activities.	"Everywhere I've ever been, I've gardened. And . . . then talk about it on Sunday—to talk about cultivating and pulling weeds as a therapeutic activity, and sometimes in our congregations we cannot weed out difficult challenges, but at least I can in my garden. And so all of that just works together for me."
Create routines, especially morning spiritual devotion routines. Proactively look at the week ahead and make a plan to prevent neglecting priorities in the face of too much work.	". . . that's a focal point of my life, in terms of having a God view of things, instead of me waking up in the morning with my own agenda, just allowing the word of God to wash over me and refocus my heart on the things of God and the way God looks at the world." ". . . I am an introvert . . . but I have to balance all the putting myself out with a lot of quiet time and I think this is when it has worked best for me in the morning. . . . It's just me and God, and you do your scripture reading, you do your prayers, you do your sacred reading, not always studying for a sermon." "Every week plan: where's my downtime, where's my exercise time, where's my spiritual growth, personal spiritual growth time apart from sermon preparation?"

Table 3
Suggestions from flourishing participants on establishing and communicating boundaries

Overarching suggestions from participants	**Specific ideas from participants to enact the suggestions**
Arrange your schedule in a way that works for you.	• Schedule things in lumps so that you have back-to-back meetings, thus protecting a block of time for either family or non-meeting work. • Schedule evening meetings all on the same night so that only one night is taken up by church-related issues.
Manage your phone and email; don't let them manage you.	• Don't look at email on your day off. (You may have to look at the subject line of emails to determine whether there is an emergency.) • Ask others to text you if there is an emergency so there is no real need to look at email. • Do not talk or look at the phone while exercising. • Turn the phone off at night. • Don't read email right before bed.
Give yourself permission to take care of yourself.	• Every day is different; be aware of that and in the midst of immersing yourself in pastoral work, also tend to your own emotional and physical needs. Here is a quote from one participant to illustrate: "So just trying to look at the day as a whole and say, okay I've only got a limited amount of personal energy, where is that energy going to be best applied? And if I feel like I need to spend time talking with my wife and eating lunch with her, then I arrange my day so that I can do that. If I feel like I just need to spend time with a book or walk or go to the gym and work out, then I don't beat myself up over blocking out those hours to do that, because it would be so easy just to go all day and be completely exhausted at the end of the day."
Get clear on expectations.	• Discuss the expectations of the clergy person's commitments with congregants / their leadership. • Discuss priorities, because it's not possible for the clergy person – or the congregation -- to do everything. Discuss this in terms of mission, as illustrated by this participant quote: "I can't be at everything and do everything. And if that is the expectation, then you're going to limit the growth and the ability of this church to do what God's called them to do based on that pastor's individual personal energy. So I try to do what I think are the important things."

Talk with congregant leaders about the need for clear and direct communication.	• When discussing communication, you can frame it theologically, as illustrated by this participant quote: "I really like for us to operate under the auspices of Matthew Chapter 18. If you have a concern with me or with anybody else, go one-on-one to that person and try to work it out and don't run around and tell everybody else what your gripe or grumble is. … We're in this together as a part of a team. And I'm not perfect and you're not perfect, we're moving onto perfection and one of the ways we do that is by respecting each other and caring enough about each other to speak the truth in love."
Communicate your schedule to others.	• Give your vacation days in advance. • Use a calendar that all can see and put on it time for prayer, sermon preparation, and Sabbath.