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DENOMINATIONAL SUPPORT FOR CLERGY MENTAL HEALTH

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To date, minimal research has addressed the actual services provided to maintain the mental health of leadership in the church. Three major Protestant denominations were consulted with in this study, including a total of 434 pastors across the United States. Among these three denominations, a range of services are now being offered to support clergy, with services such as time off, prayer support groups, and clergy retreats among the most valued, adequately provided, and utilized. Still, clergy do not see the provision of services as fully adequate, and report a number of obstacles to utilizing services. Generally, the most highly rated obstacle was financial limitations, followed by difficulty getting time off and concerns about confidentiality. Recommendations offered by clergy respondents are provided.

According to recent polls approximately 82% of US Americans claim to have a Christian religious preference, including Protestant, Roman Catholic, or other Christian groupings (Newport, 2004). Polls also indicate that over 40% of US Americans regularly attend church (Newport, 2007b). Judging from these numbers, Christianity is a major social institution in the United States and church attendance is a common part of life for many individuals.

Churches provide guidance and direction for their members, supporting families, strengthening interpersonal relationships, affirming moral values, and the like. In addition to being a place of spiritual worship, the social institution of the church is instrumental and significantly impacts society by providing meaning, support, and affiliation. In fact, US Americans rank churches near the top among institutions that they place a great deal of confidence, more so than banks, the US Supreme court, public schools,

the medical system, and many others (Newport, 2007a). Churches also typically serve many functions in communities, including community development, social connection, meeting the basic needs of the poor, providing supportive care and visitation of the homebound and hospitalized, counseling individuals and families with mental health needs, and so on.

The most prominent and visible people responsible for organizing, managing, and leading churches are clergy. Not only are clergy responsible for directly providing many of these services, but their leadership is essential and influential in the moral, mental, and social formation of the 120 million Americans who attend church (Newport, 2007b), so much so that clergy are among the most trusted professionals in our society (Jones, 2005).

Given the responsibilities that clergy are carrying, often working long hours and making substantial personal sacrifice, the importance of mental health support becomes evident. In recent years, there have been a number of studies investigating and reviewing the mental health of clergy (Hall, 1997; Weaver, Flannelly, Larson, Stapleton, & Koenig, 2002). These studies can be synthesized into a few functional areas including stress and burnout, marriage and family adjustment, and emotional and functional impairment.

Work-related stress and burnout among clergy have been the focus of many studies (Hall, 1997) and appear to be a significant issue for clergy irrespective of religious denomination or country (Lewis, Turton, & Francis, 2007). Some research suggests that burnout is the result of systemic factors including bureaucracy, poor administrative support, and difficult work conditions. Others suggest intrapersonal factors including idealism, Type-A personality factors, narcissism, and perfectionism (Grosch & Olsen, 2000). Rickner and Tan (1994) found clergy experience excessive guilt and issues with their families of origin more frequently than other groups (Rickner & Tan, 1994). Many pastors also experience social isolation, and other

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researchers have concluded that interpersonal or relational deficits are related to the majority of psychological problems faced by pastors (Hall, 1997). Regardless of the contributing causes of burnout, it is clear that there is a substantial demand upon a clergyperson's time and energy as he or she is expected to be the administrator, teacher, preacher, counselor, and fundraiser all at once; and there is rarely a time when clergy are not on call (Weaver, Flannelly, Larson, Stapleton, & Koenig, 2002). Therefore, clergy are prime targets for experiencing stress and burnout.

Regarding marital and family adjustment, Warner and Carter (1984) found that pastors and their spouses experience significantly more loneliness and less marital adjustment when compared to laity in their denomination that are not in pastoral roles. Further, Hall (1997) identified six stressors that are problematic for all clergy couples. These include: financial stress, lack of family privacy, frequent moves, spouse being on call, spouse is busy serving others, and lack of ministry to clergy family. Further, when divorced clergy were queried about the most significant problem that led to their divorce, it was their time commitment to work that was most frequently cited resulting in a clear connection between work and marital problems.

The research regarding clergy impairment has focused almost exclusively on issues of sexual misconduct. Sexual misconduct among clergy has lasting effects on the clergy member's career, the congregation, and those involved with the sexual misconduct including the effects of impaired spirituality and decreased church attendance for those who have been abused (Brewster, 1996; McCall, 2002; McLaughlin, 1994). In a survey of extra-marital sexual behavior in ministry, Thoburn & Balwick (1998) found that 15.6% of clergy had engaged in extramarital sexual behavior. There are a number of factors that contribute to this behavior. Robison (2004) notes the importance of acknowledging the power differential between clergy and laypersons. Sadly, it is often the negligence or disregard for this power differential by clergy that has led to sexual violations. In a series of interviews with clergy who had engaged in sexually addictive behavior or sexual misconduct, Noyes (1997) found social isolation, lack of personal accountability for time and behavior, early sexual encounters, exposure to pornography, cognitive distortions regarding the nature of their behavior, emotionally and/or physically absent fathers, and limited training or education in

issues of sexuality all contribute to problematic sexual behavior.

Given the important role of clergy in the church and the various mental health issues that commonly affect clergy, one must consider the impact of clergy mental health on the church. Little, Simmons, and Nelson (2007) discuss this issue noting that leader health can significantly impact organizations. Thus, if a leader is absent, makes faulty decisions, or leaves the organization as the result of poor health, it can create anxiety in his or her followers and considerably reduce the effectiveness of the organization. For this reason, preventive and restorative care for the clergy become important considerations not only for the clergy themselves, but also for the church as an organization. Simply put, supported pastors tend to produce healthier churches (Gilbert, 1987). To whatever extent mental health issues may be associated with job stress, one might expect clergy employers to meet these mental health needs. This not only would be beneficial to the individual clergy, but also the church members who are being led by the clergy person and the denomination as a whole. Unfortunately, as Meek et al. (2003) found, many pastors experience a lack of organizational support over time, feeling that the primary emphasis of denominational leaders is increased church size rather than the health of the pastors. Meek et al. go on to note that it is common for pastors who seek mental health services to fear reprisal from their leaders as it may convey a weakness, professional incompetence, or a lack of faith.

To date, there has been minimal research assessing the actual services provided by denominations designed to maintain the mental health of clergy. Morris and Blanton (1994) explored denominational leaders' perceptions of the stressors clergy face and took a broad survey of the support available to clergy, including financial, career development, family, and psychological services. They concluded that denominational awareness was only partial at best. In terms of the specific mental health services being provided, 79% provided some form of referral service for counseling, but only 43% offered some form of counseling services and only 10% offered a confidential crisis phone service. Regarding services directed toward clergy families, 54% of denominations provided marital enrichment seminars, 39% offered family retreat and vacation centers, 29% had newsletters addressing clergy family concerns, and only 4% offered services to clergy children to help them transition during relocations. The same

authors (Morris & Blanton, 1995) also explored clergy perceptions of denominational support in six different Protestant denominations, and attempted to compare these results with their previous research on denominational support. The researchers concluded that a majority of clergy and their spouses perceived that their denominations were not providing the services they believed were most important, including support to enhance the quality of life for the clergy families.

A good deal of time has passed since Morris and Blanton published their research in the mid-1990s, and it seems likely that many denominations have increased in their support for the mental health needs of clergy. The present study assesses selected protestant denominations regarding their support of clergy mental health. Specifically, we assessed the following questions: 1) What services are being offered to support clergy mental health?, 2) To what extent are clergy aware of and utilizing these services?, 3) How important are these services to maintaining mental health?, 4) What obstacles make it difficult to access and utilize these services?, 5) What mental health issues are affecting clergy?, 6) What recommendations do clergy have for improving mental health services provided by their denominational leadership?

METHOD

Participants

Three major Protestant denominations participated in the study. To protect their confidentiality, these denominations will be referred to as Denomination 1 (D1), Denomination 2 (D2), and Denomination 3 (D3). Organizational leaders from each of these denominations, such as Superintendents, Bishops, and District Superintendents, were contacted to determine the types of mental health services currently offered by each denomination. Clergy in each denomination then participated in an online survey regarding these services and clergy mental health issues. A total of 1,186 pastors across the United States were invited to participate in the study, with 434 pastors (37%) responding.

The D1 clergy survey was sent to 86 pastors throughout three northwestern states. Thirty-three pastors (38%) participated with the survey. This included primarily Caucasian (91%) married (94%) men (87%), ranging in age from 31 to 87 years, with a median age of 53 years. Fifty-eight percent of these clergy were senior pastors, 6% associate pastors, 3%

superintendents, and 33% were working in various other roles such as youth ministry, administration, chaplain, missionary work, or had retired. On average, clergy had been working in their current position for 8 years and had been working in church leadership between 3 and 50 years. Forty-two percent of these clergy were working in a suburban church, 30% in a rural church, and 27% in an urban church.

The D2 clergy survey was sent to 130 pastors throughout four northwestern states. Forty-four pastors (34%) participated with the survey. This included primarily Caucasian (96%) married (91%) men (80%), ranging in age from 27 to 69 years, with a median age of 49 years. Fifty-seven percent of these clergy were senior pastors, 23% associate pastors, and 21% were working in various other roles such as youth ministry, worship, interim pastor, chaplain, or had retired. On average, these clergy had been working in their current position for 5 years and had been working in church leadership between 1 and 42 years. Forty-three percent of these clergy were working in a rural church, 36% in a suburban church, and 21% in an urban church.

The D3 clergy survey was sent to 970 pastors throughout 35 states in the United States of America. Three hundred fifty-seven pastors (39%) participated with the survey. This included primarily Caucasian (86%) married (94%) men (81%), ranging in age from 21 to 72 years, with a median age of 48 years. Other ethnicities represented included 4% Asian American, 3% Hispanic/Latino(a), 1% African American, 1% Native American, and 5% indicating other ethnicity. Sixty-three percent of these clergy were senior pastors, 25% associate pastors, 1% superintendents, and 12% were working in various other roles such as assistant superintendent, youth ministry, co-pastor, chaplain, missionary work, elder, or had retired. On average, clergy had been working in their current position for 6 years and had been working in church leadership between 0 and 60 years. Forty-four percent of these clergy were working in a suburban church, 28% in a rural church, and 28% in an urban church.

Instruments

Two questionnaires were developed for this study. The first questionnaire, *Actual Services Provided Survey*, was given to the denominational leader serving as the primary informant regarding the mental health services offered to their clergy. This

TABLE 1

Clergy Perceptions, Valuing, and Utilization of Services Offered by Their Denominations

Service	Extent Provided				Valued for Mental Health				Service Utilized			
	D1	D2	D3	Overall	D1	D2	D3	Overall	D1	D2	D3	Overall
Clergy retreats	3.6	3.7	3.2	3.3	4.1	3.8	3.7	3.8	77%	84%	75%	76%
Prayer/support groups	2.8	3.5	3.5	3.4	3.8	4.1	4.2	4.1	61%	79%	80%	79%
Sabbaticals	2.0	2.8	2.8	2.7	4.1	4.3	4.2	4.2	23%	14%	15%	15%
Referrals for counseling	3.0	2.7	2.7	2.8	3.5	3.7	3.8	3.8	13%	9%	24%	21%
Individual counseling	3.1	2.5	2.8	2.8	3.7	3.8	3.9	3.9	42%	21%	32%	31%
Family counseling	2.8	2.3	2.6	2.6	3.5	3.5	3.8	3.7	10%	12%	13%	13%
Educational mental health seminars	2.2	2.4	2.1	2.1	3.4	3.6	3.4	3.4	36%	40%	21%	24%
Informational mental health reading	2.1		2.2	2.2	3.2		3.4	3.4	29%		28%	28%
Mental health assessment for ordination	3.2			3.2	3.5			3.5	23%			23%
Regular meetings with clergy by designated leader	3.7			3.7	4.1			4.1	3%			3%
Restoration process for struggling pastors	3.7			3.7	4.1			4.1	3%			3%
Crisis phone		2.3		2.3		3.1		3.1		14%		14%
Time Off		3.5	3.4	3.4		4.2	4.4	4.4		79%	72%	73%
Pastoral spouses mental health seminars			2.5	2.5			3.7	3.7			37%	37%
Pastoral spouses support network			2.0	2.0			3.5	3.5			18%	18%
Pastoral support network			3.5	3.5			4.0	4.0			82%	82%

Notes. Extent Provided is extent to which clergy perceive the service to be provided sufficiently from their denomination, reported as the mean rating on a Likert-type scale, ranging from 1 (*Not at all*) to 5 (*A great deal*). Valued for Mental Health is the extent to which clergy respondents do or would value this service for the sake of mental health, ranging from ranging from 1 (*Not at all*) to 5 (*A great deal*). Service Utilized is the percentage of clergy who reported utilizing this service. Blank cells indicate that the denomination did not list this as a service provided to their clergy for mental health support. Denomination 1 (D1) consisted of 31 respondents, Denomination 2 (D2) of 43 respondents, and Denomination 3 (D3) of 324 respondents.

survey was then used to develop a list of actual mental health services provided by a denomination to their respective clergy. These denominational lists were used to customize the *Clergy Survey*, which was used to survey each denomination's own clergy. The *Clergy Survey* was identical across all three denominations, with the exception of the listing of mental health services being provided, as these were tailored specifically for each denomination. These surveys included questions related to the mental health services provided to clergy as well as demographics of the participant, the mental health issues experienced by clergy, the desire or value of mental health services, and rating of obstacles to mental health services. Answers were quantitative in nature, using a 5-point Likert-type rating scale. There were also opportunities for open-ended responses regarding suggestions for improving clergy mental health services and examples of experiences of mental health support. Surveys were administered via an online survey site.

Procedure

Within each denomination, an organizational leader was identified who oversaw a large group of clergy and had knowledge of the mental health related services provided to clergy by their denomination. After approval and consent to participate in this research was given by the organization and selected leader, the organizational leader completed the *Actual Services Provided Survey* to identify all of the mental health related services provided by the denomination to their clergy. With this list of services, the *Clergy Survey* was created to ask clergy about these services, with each *Clergy Survey* customized for the particular denomination being surveyed. The denominational leader then sent out the survey invitation via email to clergy. To increase participation, those who complete the survey were provided an opportunity to enter a drawing to win one of eight 25-dollar gift cards, though names of participants were filed separately from survey results to maintain confidentiality of participants.

RESULTS

The denominational leaders reported offering a number of services to support their clergy's mental health needs, listed in Table 1. As seen in the table, not all services were identified by the three denominations. Clergy ratings of the extent to which the ser-

vice is available, how much they value the service, and whether they have utilized the service are also reported in Table 1.

For services provided by all three denominations, the overall availability ratings were ordered from the most available to the least available (see Table 2). Based on a repeated measures analysis of variance (ANOVA), significant differences were found among the ratings for various denominational support services, Wilks' $\lambda(6, 392) = .390, p < .001$, which then justified profile analyses using paired-sample *t*-tests to determine which items were significantly lower than the preceding item on a rank-ordered list using a conservative α of .01 to control for Type I error. Difference on adjacent means can be found in Table 2.

Similarly, clergy ratings of the value of each service were ordered from the most valued to the least valued (see Table 3). A repeated measures ANOVA revealed significant differences among the various ratings, Wilks' $\lambda(6, 392) = .597, p < .001$, which justified a profile analysis. Again, paired-sample *t*-tests were used to look for differences between adjacent items, employing a conservative α of .01 to control for Type I error. Difference on adjacent means are identified in Table 3.

Clergy were also asked to rate 15 potential obstacles that make accessing mental health services difficult. The 15 items are listed in order of average ratings in Table 4, with the highest rated items at the top of the list. Differences were evaluated with within-group analysis looking at the overall rating differences among the 15 obstacles. Significant differences were found on a repeated-measures ANOVA, Wilks' $\lambda(14, 375) = .292, p < .001$, which then justified profile analyses using paired-sample *t*-tests to determine which items were significantly lower than the preceding item on a rank-ordered list using a conservative α of .01 to control for Type I error. Adjacent item differences are identified in Table 4.

Also, clergy were also asked to rate how much they have been affected by various mental health concerns. Table 5 summarizes these 16 concerns, listed in order of average ratings, with the highest rated items at the top of the list. The percentage of clergy reporting various levels of being affected by each issue is also included. Differences were again evaluated with a repeated-measures ANOVA and overall differences between items were noted, Wilks' $\lambda(15, 372) = .122, p < .001$. This justified profile analyses using paired-sample *t*-tests to determine which items were significantly lower than the preceding item on a rank-ordered list using a

TABLE 2*Clergy Ratings of the Extent to Which Each Service is Available, Rank Ordered*

Service Identified by Denomination	Rating
Prayer/support groups	3.4
Clergy retreats	3.3
Individual counseling*	2.8
Referrals for counseling	2.8
Sabbaticals	2.7
Family counseling	2.6
Educational mental health seminars*	2.1

Notes. N=324.

Rating is the extent to which clergy perceive the service to be available from their denomination, reported as the mean on a Likert-type scale, ranging from 1 (*Not at all*) to 5 (*A great deal*).

*This item is rated significantly lower than the preceding item on the list, $p < .01$.

TABLE 3*Clergy Ratings of the Extent to Which Each Service is Valuable, Rank Ordered*

Service Identified by Denomination	Rating
Sabbaticals	4.2
Prayer/support groups	4.1
Individual counseling*	3.9
Referrals for counseling*	3.8
Clergy retreats	3.8
Family counseling	3.7
Educational mental health seminars*	3.4

Notes. N=324.

Rating is the extent to which clergy do or would value this service for the sake of mental health, reported as the mean on a Likert-type scale, ranging from 1 (*Not at all*) to 5 (*A great deal*).

*This item is rated significantly lower than the preceding item on the list, $p < .01$.

conservative α of .01 to control for Type I error. Adjacent item differences are identified in Table 5.

Finally, clergy were asked in open-ended questions to provide positive or negative examples or experiences of receiving mental health support, and to offer suggestions for how the mental health needs of clergy could better be supported by denominations. It is beyond the scope of this paper to report the themes of their responses in detail, though some of the qualitative findings will be used to interpret and discuss the quantitative findings in the Discussion section that follows.

DISCUSSION

It is clear that denominations are providing mental health care to their clergy in a number of ways.

These include retreats, conferences, counseling, support groups, informational reading, time off, and more. In comparison with Morris and Blanton's (1994) research, it seems that denominational provision of mental health services has improved since the early 1990's, though the denominations being assessed differed. Although specific results varied between the three different denominations surveyed, there were many striking similarities and themes represented across denominations.

Similarities Across Denominations

Clergy value the mental health services being provided to them, and many of these services are being utilized at high rates. Services such as time off, prayer

TABLE 4
Clergy Ratings of Obstacles to Accessing Mental Health Services, Rank Ordered

Obstacle	Rating
Financial limitations*	3.6
Difficulty in taking time off work because of a lack of job support	2.9
Concerns about confidentiality	2.9
Lack of awareness of available mental health services	2.9
Fear of reprisal by denominational leaders (i.e. loss of job, respect, demotion)	2.7
Lack of denominational support for the mental health needs of pastors	2.7
Feeling shamed by your congregation	2.6
Lack of Christian psychologists with a similar worldview	2.6
Lack of denominational knowledge of the mental health issues affecting clergy	2.6
Being perceived as dysfunctional	2.6
Lack of denominational concern for the mental health needs of pastors	2.6
Lack of available mental health services/resources	2.4
Seeking mental health services may reflect a lack of faith in God*	2.0
Personal conflict with psychological practice*	1.8
Prior personal experience with mental health services*	1.6

Notes. N=389.
 Rating is the extent to which clergy perceive the item to be an obstacle in seeking mental health services, reported as the mean on a Likert-type scale, ranging from 1 (*Not at all*) to 5 (*A great deal*).
 *This item is rated significantly lower than the preceding item on the list, $p < .01$.

TABLE 5
Clergy Ratings of Personal Mental Health Issues, Rank Ordered

Issue	Rating	Midpoint or Higher
Job Stress	3.6	87%
Emotional Turmoil*	3.1	73%
Burnout	3.1	67%
Difficult Job Transition*	2.6	46%
Anxiety	2.4	44%
Depression	2.4	43%
Interpersonal/Relational Difficulties*	2.1	30%
Anger	2.1	32%
Family Turmoil	2.1	31%
Difficult Family Adjustment to Ministry Change	2.1	31%
Marital Problems	2.0	28%
Difficulty Getting Along with Others*	1.8	17%
Troubling Childhood Memories or Experiences	1.7	19%
Sexual Misconduct*	1.3	10%
Divorce*	1.1	3%
Substance Abuse	1.1	2%

Notes. N=387.
 Rating is the extent to which clergy report being affected by this mental health problem, reported as the mean on a Likert-type scale, ranging from 1 (*Not at all*) to 5 (*A great deal*).
 Midpoint or Higher is the percentage of clergy endorsing a 3 or greater on the 5-point scale.
 *This item is rated significantly lower than the preceding item on the list, $p < .01$.

support groups, and clergy retreats are among those that are most adequately provided by denominations and utilized by clergy. Sabbaticals are also highly valued but not offered as often, perhaps because of the substantial cost to denominations and congregations.

It is also important to consider factors that hinder clergy from accessing and utilizing services. By far, the most highly rated obstacle in all three denominations was financial limitation, which was also reiterated in open-ended responses by clergy. This was typically followed by difficulties getting the time off necessary to engage in these services, concerns about a lack of confidentiality, and limited awareness of the services available. As suggested by Meek et al. (2003), the fear of jeopardizing one's career by seeking mental health care was also rated as a concern for clergy. However, whereas Meek et al. also reported that clergy feel utilizing mental health services may reflect a lack of faith, clergy in the three denominations assessed did not support this notion as ratings of this concern were low.

Although clergy face a number of obstacles to accessing mental health services, they clearly have mental health needs. Respondents indicated significant concern about job stress, emotional turmoil, and burnout, among other issues, which is consistent with past research on stress and burnout (Lewis, Turton, and Francis, 2007). This is a potential liability for churches and denominations, as it seems they may be at risk of losing pastors to burnout. Considering the various organizational issues contributing to clergy burnout, including bureaucracy, administrative support, and workload (Grosch & Olson, 2000), denominational leadership can significantly reduce burnout by addressing these issues. In addition, the interpersonal issues that contribute to burnout can be effectively addressed with services such as denominationally supported counseling.

Suggestions for Improvement

Respondents offered a number of viable suggestions to improve the denominational support of clergy mental health. First, clergy would like their denominational leaders to be more aware of individual pastors and their wellbeing. One example of this being done well was in D1 where designated leaders regularly initiate contacts and visits with their pastors for support. Clergy would also like to see increased communication of the services available to them, as this is essential to utilizing these services. Mental

health educational opportunities would also help pastors, their congregations, and leadership to be more sensitive to the mental health needs of pastors. The implementation of denomination guidelines and standards for mental health services was also emphasized. For example, leadership could promote and support standards regarding time off and sabbaticals so that clergy in all churches received adequate respite. Given the financial obstacles many clergy face, denominational funding for mental health services seems essential if clergy are going to be able to access these services. Clergy would also like to have improved access to confidential and spiritually oriented mental health care, possibly through a referral list or a professional contracted through the denomination. Finally, the implementation or improvement of pastoral support networks seems to be a cost effective and highly valued component for maintaining clergy mental health.

Future Directions

In considering these mental health concerns and suggestions, it is also important to highlight the great strides that have been made to better support clergy mental health needs. This is not only evident in the current body of research of clergy mental health, but is also evident in the numerous clergy narratives detailing encouraging, positive, and supportive relationships with their denomination and leadership. At the same time, it is important to raise awareness of clergy needs in light of the personal stories of private struggle, lost jobs, fear, and pastors who feel they have been left to fall by the wayside because of a lack of support. Raising awareness may start with continued consultation and collaboration between denominational leadership and mental health professionals. It is out of these meetings that clergy's concerns are heard, effective strategies are developed, and change happens.

Limitations

Finally, it is important to note some of the limitations of the data provided in this report. First, the data are offered primarily from clergy perspective and not all variables were defined, thus it is impossible to know how closely the reported behaviors align with actual behaviors (e.g., a clergyperson reporting that he or she feels depressed much of the time may look different between clergy because this is based on self perception and their own definition of depression). Second, while the Likert-type rating

scales provided a convenient and quick way for clergy to report their opinions, rating scales compromise some precision by forcing participants to classify their opinions into ordinal data. Third, as with any survey data, there is a self-selection bias of clergy who chose to respond and participate in the study, which may have impacted the results. Fourth, differing from Morris and Blanton's (1994, 1995) studies, this research took a more in-depth look at only three Protestant denominations, making it difficult to generalize these results to all clergy or all denominations. Fifth, in the initial search for denominations to consult with, it was evident that many other denominations do not have an organizational structure or hierarchy that would be responsible for supplying mental health services. In denominations where there is little to no organizational hierarchy, the burden of clergy care often falls entirely on the local church's lay leadership.

CONCLUSION

Within the three denominations included in this study, a range of services are now being offered to support clergy, with services such as time off, prayer support groups, and clergy retreats ranking among the most valued, adequately provided, and utilized. These services become all the more important as we consider concerns about job stress, emotional turmoil, burnout, and other issues that were frequently endorsed by many clergy. While attention to clergy mental health may be improving with increased services, it seems there is ample room for improvement, as many clergy do not see the provision of these services as fully adequate. This is likely related to a number of variables such as the lack of awareness of these services among clergy and that there is often a lack of consistency or standards for implementing these services throughout denominations. Further, clergy face a number of obstacles that prevent them from utilizing services, with the most highly rated being financial limitations, difficulties getting the time off necessary to engage in these services and concerns about a lack of confidentiality.

Given these concerns, clergy made a number of suggestions to improve denominational support of clergy mental health. In addition making overall improvements to the services provided, it seems that increasing awareness of available services would be an important first step. Addressing the issue of financial limitations by providing funding or insurance

covering the expense of these services would be helpful. Finally, improving education regarding clergy mental health seems important for clergy and leadership to become more aware and equipped to address mental health concerns.

By equipping leadership with increased understanding and awareness of their clergy's mental health needs, it is hoped that denominations will continue to expand their support of mental health services to their clergy. Further, with increased access and use of mental health services, issues such as stress, burnout, and other psychopathology will be reduced in clergy. This is expected to not only improve clergy wellbeing, but also have a positive ripple effect throughout church congregations and society as a whole.

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