Supporting UK Baptist Clergy Health, Wellbeing, and Self-care: Intervention Development and Testing

Jamie I. Green, R.N. BSc, MSc, FHEA, MISMA

Thesis submitted to the University of Nottingham for the degree of Doctor of Philosophy

August 2024

Abstract

Background: An examination of the current national and international literature regarding Christian clergy health and wellbeing indicates significant health deficits against comparative adult populations. To date, UK research is scant, with no published works concerning the holistic health, wellbeing, and self-care behaviours of Baptist church clergy. The potential influence of clergy within communities, known health disparities, and the lack of UK-specific research highlight an imperative for further investigation in this occupational group.

Methods: Four interrelated investigations are presented in this thesis. The first comprises a quantitative profile of clergy health and wellbeing based on survey responses from 55 UK Baptist clergy. Study two used qualitative methods to explore the rich lived experiences of 20 UK Baptist clergy in relation to their barriers and facilitators to positive self-care behaviours. Study three presents a systemised literature review of clergy health and wellbeing interventions, including what elements are shown to be acceptable, feasible, and effective at promoting behaviour change. The final component builds on the first three stages and considers the views of 11 UK Baptist clergy on the acceptability and feasibility of a tailored holistic self-care intervention.

Results: Data from Study one highlighted that respondents' health and wellbeing profile was generally similar or inferior to that observed in clergy from other denominations and wider adult population. In the interview phase, clergy indicated a range of overlapping self-care barriers with particularly prominent features in the social and spiritual domains. Identified facilitators included the necessity to take time out, the experience of inter-related health facets (mental and physical) and biblical imperatives to self-care e.g., the example of Christ. Study three identified prominent characteristics from 18 international clergy health and wellbeing interventions. These components included taught sections, self-reflection,

group work, and a theological foundation. The final intervention showed acceptability and feasibility across evaluation criteria.

Conclusions: The research in this thesis adds to the limited scientific knowledge base on clergy health and wellbeing in several ways. The studies presented are the first of their kind involving UK Baptist clergy. Findings have highlighted the need for change and improvement in clergy health and wellbeing at the individual, church, and support agency level. Additionally, these works provide a valuable foundation and framework for future health and wellbeing research and interventions in Baptist clergy.

Preface

Thesis Stimulus

On the 22nd May 2017 the Manchester Arena was hit by a suicide bomb killing 23 people, including the bomber. Following the attack, in September 2017 Dr Nasser Kurdy was stabbed outside a mosque in Altrincham, my then hometown, in an anti-Islamic hate crime. Anecdotally, I observed these events, both the bombing and retaliation hate crimes, deeply affecting my community. In the wake of the events, I observed an outpouring of emotional and practical gestures from faith leaders (and local citizens) supporting and upholding those in physical, mental, and/or spiritual crisis. However, at times, it was evident this support was given to the detriment of the leader's wellbeing. The year's events appeared to be taking their toll, with some leaders exhibiting noticeable symptoms of poor self-care. This was not the first time in my Christian journey that I have witnessed faith leaders (namely clergy) succumbing to compassion fatigue, stress, and general ill-health owing to job demands. These historic and current events provided the inspiration for this thesis investigation. Upon discussion with my supervisor, I expressed my desire to scientifically explore the beliefs, behaviours, and general health profiles of Christian clergy. I wanted to offer the research field and denomination results which could further inform practice and policy improvement.

The initial stimulus of this thesis was born out of a time of community crisis. Moreover, the global issues of 2020 onwards have further solidified the necessity for improved clergy self-care education and support. Pandemic-era research indicates various UK denominations have seen an increase in church attendance and interest, and the church remains, for many, an essential community hub (Evangelical Alliance, 2020; Giles & Dyas, 2021). Yet, research also indicates an increase in clergy and congregant mental (ill)health and relationship issues, increased church financial concerns, and clergy role redevelopment

(Evangelical Alliance, 2020; McFerran & Graveling, 2022). It is my hope, therefore, as job demands and pressures appear to be increasing, that the research contained in this thesis will provide a useful contribution to the contemporary issue of clergy self-care.

Thesis Structure

Chapters one and two introduce the field, present a mapping literature review, and set the theological context. Behavioural drivers for many Christians are rooted in theology (Baptists Together, 2013; Wright, 2016). Examining and defining the theological basis for health and wellbeing choices, beliefs, and behaviours, therefore, is a valuable foundational step for impactful Christian research. This section concludes by indicating what is known and not known, to date, from clergy health and wellbeing research, presenting a rationale for the studies described in subsequent chapters.

Chapter three details the first stage of investigation, profiling the current health of practicing Baptist clergy. This exploratory investigation profiles the health and wellbeing of 55 Baptist church leaders and examines the results against comparative adult populations and clergy groups. The chapter concludes by presenting a rationale for further exploration into the barriers and facilitators for clergy self-care, based on the observed health disparities.

Chapter four discusses the findings from 20 Baptist clergy interviews which explored perceived barriers and facilitators to holistic self-care. Two reflexive thematic analyses (Braun & Clarke, 2006) were conducted using the socioecological model of health as a framework for theme generation. The chapter concludes by presenting the interviewees' interlinked understanding of health and their specific barriers and facilitators to self-care.

Chapter five details the systematised literature review of clergy health and wellbeing interventions. The chapter concludes by drawing together key features of the interventions, with these informing Study four.

This final study (Chapter six) explores the acceptability and feasibility of an intervention to support and promote self-care in Baptist clergy. This intervention was piloted with 11 participants and showed feasibility and acceptability across the evaluation criteria. The chapter concludes by presenting some possible modifications for future piloting and full-scale roll out of the intervention.

Finally, Chapter seven draws together the research findings, conclusions, contribution, strengths and limitations, and the place of these works in the wider research field. Finally, the chapter presents evidenced based recommendations for future practice using the socioecological model of health.

Table 1
Summary of Thesis Research Questions, Aims, Methods, and Location Within the Thesis

Research questions	Study	Data sources	Methods used	Thesis chapter
1. What is the holistic (spiritual, mental, physical, social, financial, and occupational) health and wellbeing profile of UK Baptist clergy? 2. How does the sample's health and wellbeing profile compare to that observed in the extant literature pertaining to clergy from other Christian denominations and general UK adult populations?	One	Questionnaire responses	Descriptive analysis	Three
What are the perceived barriers and facilitators to the holistic (physical, mental, spiritual, and social) self-care practices of UK Baptist clergy?	Two	UK Baptist clergy online mediated interviews	Reflexive thematic analysis	Four
Aim - To explore the existing literature and ascertain the key characteristics, approaches, and methodologies to include / exclude to promote maximal fit and efficacy in a UK Baptist clergy health promotion intervention.	Three	Published works pertaining to clergy health and wellbeing interventions	Systematised literature review	Five
To what extent is a tailored holistic self-care promotion intervention considered acceptable and feasible by UK Baptist clergy?	Four	Clergy pre and post-intervention survey responses	Critical evaluation against Gadke et al.'s (2021) criteria	Six

Note - Nazarene Clergy Exclusion

This investigation originally sought to compare findings of the small Church of the Nazarene denomination's clergy with the larger Baptist denomination. Participation by the Church of the Nazarene was limited, and an insufficient number of responses were obtained in the first two studies to conduct any meaningful analyses. As such, the pragmatic approach was taken to exclude the minimal gathered responses from analyses and discontinue exploration of this denomination. It is understood, however, that this denomination's health and wellbeing may be an area for necessary future research.

Conference Presentations

Conference presentations and posters can be found in Appendix R.

2022 (March) – Green, J. (2022, March 29). *Baptist clergy: Investigating barriers, facilitators, and promoting holistic self-care* [Oral presentation]. Sue Watson Postgraduate Presentation, The University of Nottingham, virtual event.

2020 (September) – Green, J. (2020, September 18). *Baptist church clergy health and wellbeing self-Care* [Oral presentation]. School of Medicine Research Impact Forum, The University of Nottingham, virtual event.

2019 (November) – Green, J., Houdmont, J., & Thomson, L. (2019, November 6-9). *Baptist church clergy health & wellbeing self-care: A mixed methods study* [Poster presentation]. American Psychological Association Annual Work Stress and Health Conference, Philadelphia, PA, United States. Retrieved October 15, 2024, from https://sohp-online.org/wp-content/uploads/2024/08/WSH-2019-program.pdf

PhD Adjacent Achievements

During my studies, I had the opportunity to develop my presentation and teaching skills through the University of Nottingham Researcher Academy. These opportunities helped fortify my skill base for the confident and pedagogically sound design and delivery of the intervention described in Chapter six.

- 2021 (July) - Fellowship with Advance HE
- 2020 (June) - Preparing to Teach in Higher Education certification

In 2020 I reflected on my academic experiences as a student with learning differences and published a support article in postgraduate psychology journal, PsyPAG:

Green, J. (2020). 10 top tips for completing your postgraduate studies with a learning difference. *The Quarterly (PsyPAG Quarterly),* (117), 34-37. https://doi.org/10.53841/bpspag.2020.1.117.34

Acknowledgements

Dr Jonathan Houdmont, thank you for your seemingly endless patience, kindness, guidance, and encouragement. Your gentle and thoughtful supervision has been undoubtedly an immense blessing throughout this process. I could not have prayed for a better supervisor.

Dr Louise Thomson, thank you for your encouragement in the early stages of this PhD. Your kind words helped to settle my nerves and dispel my feelings of imposter phenomenon.

To my study participants, a heartfelt thank you for giving your precious time, for your trust, candour, devotion to Christ and our communities.

To Reverend Tim Fergusson and the Baptist Union of Great Britain, thank you for your endorsement of the research, for being on hand to answer my many queries, and for your faith in me.

Special thanks to Dr Graham Meiklejohn, Rob Campbell, Ruth Rice, Susanna and Jeremy Smith, Reverend Deirdre Brower Latz, Trevor Rowe, Greg Condon, Chris Duffett, Glen Cormack, and the team at NLBC for your prayers, support, and help promoting the studies.

To my support workers Karen Marsh and Dr Paul Barr, thank you for providing a skilled mix of study support and pastoral care that has been invaluable throughout this process.

Finally, thank you to the two greatest encouragers, my Mam and Dad. Thank you for always being available for a drink and a chat. And throughout world issues, housing problems, and endless internet failures, being my two greatest cheerleaders. I love you ‘mega and then some’.

Dedication

Patrick, my love, words cannot express my gratitude for your love, care, and support throughout this process. I could fill this thesis and then some with my appreciation. Thank you for your bountiful patience, cups of tea, pep talks, prayers, design work, silly dances, and general awesomeness that is you. I can’t wait to start the next chapter with you, my best friend.

Luca, Evie, Eva, Ruari, Hugo, Nell, Albert, and Henry, always be yourselves, and reach for your dreams. You are loved beyond measure.

Table of Contents

Index of Tables

Index of Figures

List of Abbreviations

ACAS – Advisory, Conciliation and Arbitration Service

BMI – Body mass index

BNSQ – Basic Nordic Sleep Questionnaire

BUGB – Baptist Union of Great Britain

CMD – Continuing ministerial development

COM-B – Capability, Opportunity and Motivation – Behaviour

CPD – Continuous professional development

ILO – International Labour Organization

IOSH – The Institution of Occupational Safety and Health

MHFA – Mental Health First Aid

MS – Microsoft

NHS – National Health Service

NICE – National Institute for Health and Care Excellence

NPAQ – Nordic Physical Activity Questionnaire

OLBI – Oldenburg Burnout Inventory

ONS – Office for National Statistics

RA – Researcher Academy

SHALOM – Spiritual Health and Life Orientation Measure

SWEMWBS – Short Warwick-Edinburgh Mental Wellbeing Scale

UMC – The United Methodist Church

WHO – World Health Organisation

WRRQ - Work Related Rumination Questionnaire

Chapter 1: Introduction to the Theological Context and Key Terms

1.1 Thesis Overview

This thesis explores the holistic health and self-care beliefs and behaviours of UK Baptist clergy using a four-part sequential investigation. Due to the lack of UK works, and the clear health disparities clergy in other denominations and countries are experiencing, this thesis aims to break ground on a new area of UK Baptist clergy health research. The investigations aim to profile health, explore self-care drivers, and investigate health behaviour change promotion in view of offering professional recommendations for real-world practice.

1.1.1 Context and Author Contribution

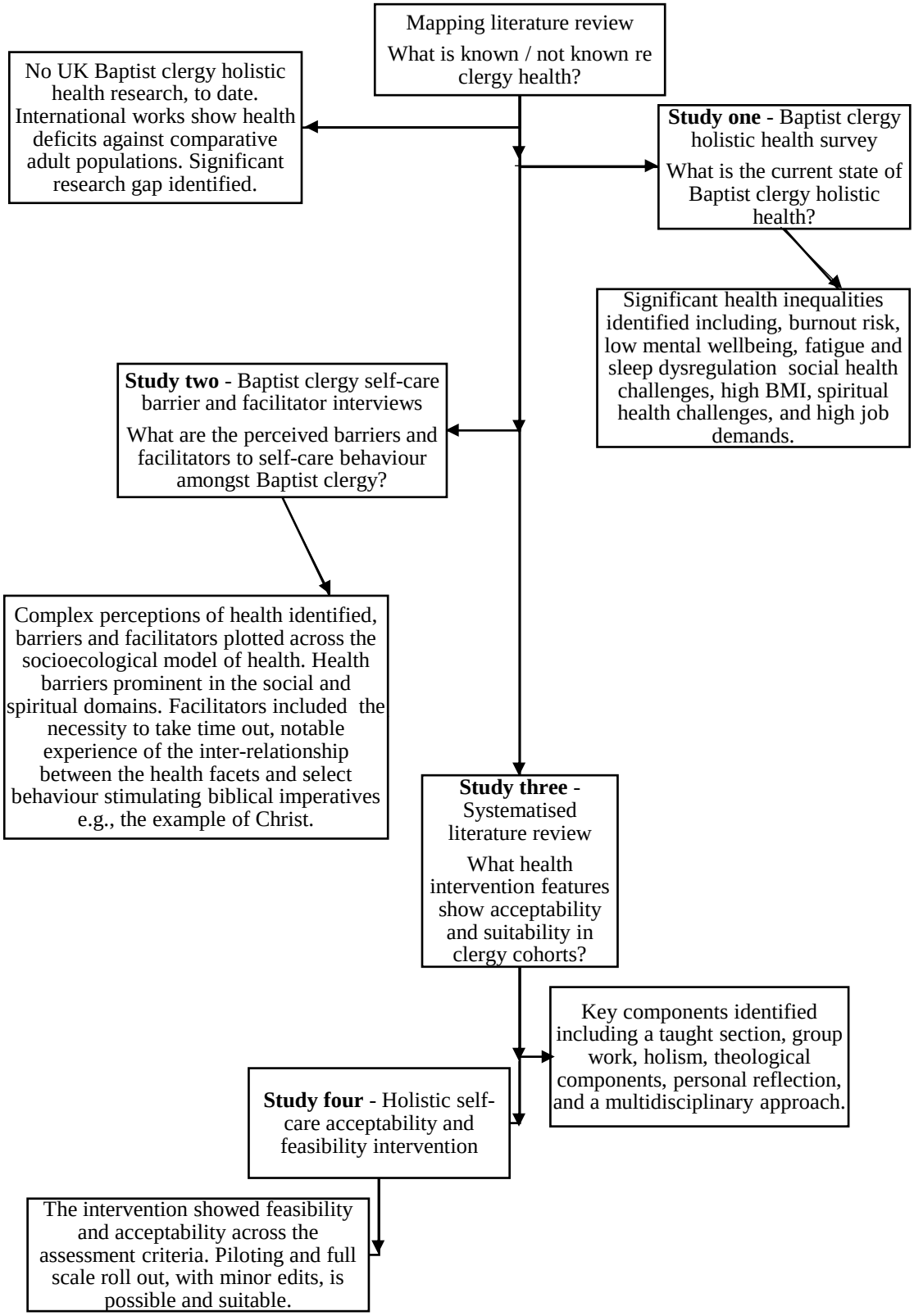
This four-stage investigation was designed, funded, and conducted by the author in sole fulfilment of the degree of Doctor of Philosophy. As a practicing Christian, the author's anecdotal observations of poor clergy holistic health and self-care stimulated the research. The work, although supported by the Baptist Union of Great Britain, did not receive any organisational or academic contributions beyond traditional PhD supervision.

1.1.2 Research Approach

The works conducted in this thesis comprise four interrelated studies where the results of each investigation provided a foundation and / or framework for the approach in the subsequent studies (Figure 1).

Figure 1

Thesis Investigation Flow Diagram



1.1.3 Chapter Overview

This chapter introduces the theological basis of holistic health and self-care in the Protestant trinitarian context. Proeschold-Bell et al. (2011) state that when considering an effective intervention, one must explore the individual's daily demands and pressures, as well as the specific cohort philosophies and beliefs. Exploring and understanding the doctrine of bodily care in the Christian context aids in understanding why some may overlook or neglect self-care. Notably, the examination of the biblical principles provides a clear directive for clergy to protect and promote health and wellbeing as a core 'aid' in the Great Commission (Jesus' directive to teach and make disciples of all peoples, [section 1.3.2]).

1.2 Introduction

Many Christians emphasise the importance of spiritual health, taking steps through prayer, meditation on the word (the Bible) and fellowship with other believers, to strengthen their spiritual health. However, often care of the body, mind, and other facets of holistic health, are not offered the same consideration, with some influencers within the Christian church deeming the self-care movement as theologically irrelevant, sinful, and self-indulgent (Fuller, 2018). Christians look to the Bible for their life reference. However, emphasis on texts such as Colossians 3:2, "Set your minds on things that are above, not on things that are on earth," and 1 Samuel 16:7, "Do not look on his appearance or on the height of his stature, … for the Lord does not see as mortals see; they look on the outward appearance, but the Lord looks on the heart." (New Revised Standard Version Bible: Anglicised, 1989/2017) and the further texts in 1 and 2 Corinthians regarding heavenly or imperishable bodies, have caused some to abandon the good stewardship of their

earthly, perishable bodies in favour of spiritual activities. Many post-reformation trinitarian denominations often deem the spiritual welfare directives in these texts as somewhat more important than care of a body that will one day be replaced, as indicated in 2 Corinthians 5:1-10 (New Revised Standard Version Bible: Anglicised, 1989/2017). Ultimately, Jesus' message in John 3:6-8 (New Revised Standard Version Bible: Anglicised, 1989/2017) that humans are spiritual beings residing in an earthly vessel (the body) takes precedent, with many concluding that the greater emphasis should be on the spirit or soul over the body.

From a theological perspective, however, holistic care of the body is prevalent in the foundations of many Christian denominations. Methodist minister John Wesley, for example, was especially fervent in his care of the body. A keen equestrian, he kept several contraptions such as his Chamber Horse, akin to modern gym equipment, to keep in shape when the riding season was over (Iovino, 2017). The North Eastern Benedictine monks showed great restraint and commitment to their dietary intake, consuming healthful vegetarian, pescatarian and vegan diets (Lawrence, 2019). The Rule of St. Benedict, a guidebook to monastic life written in the sixth century, sets out clear rules for eating and drinking and restoring the body from illness (The Holy Rule of St. Benedict, 516/1949). Dating back further, references to the Order of the Widows, who later developed into learned women of theology (Kroeger, 1988) sought to meet the holistic needs of often marginalised and forgotten societal groups. Care was offered that aimed to improve physical and mental health, preventing social isolation, poverty, and by extension death (Kaveny, 2005). This ancient trend of self-care is scripturally sound when examining several biblical texts such as Romans 12:1, "I appeal to you therefore, brothers and sisters, by the mercies of God, to present your bodies as a living sacrifice, holy and

acceptable to God, which is your spiritual worship." (New Revised Standard Version Bible: Anglicised, 1989/2017). However, despite doctrine remaining unchanged, today's Christian leaders, in some denominations, appear less focussed on holistic self-care. Global research as explored in Chapter two, shows leaders giving of themselves to the point of burnout, type II diabetes, cardiovascular disease, and other serious physical and mental illness leading to significantly increased mortality rates against comparative adult populations (Cowper, 2012; Lifeway Research, 2015; Proeschold-Bell & LeGrand, 2010; WesPath Benefits / Investments, 2015; 2017; 2019).

The following passage from notable Christian author Selwyn Hughes (2010) highlights the importance of self-care as an essential component to *whole* Christian living:

> It is accepted today that body and soul are in unity, that a sick soul can produce a sick body, just as a healthy spirit contributes to a healthy body. It also works the other way around – a healthy body can contribute to good emotional and mental health. We Christians tend to overemphasise the spiritual side of life while underestimating the importance of physical facts like body chemistry, weather, water, air pollution, and nutrition. But through ignorance of the way in which body and soul are related, we succeed only in tearing them apart. I believe what is said about husband and wife in the marriage service can also be applied to the body and soul: "Therefore what God has joined together, man must not separate" (Mt 19:6).
>
> A good pianist may be able to get a lot out of a poor instrument, but he cannot give full expression to the music if the piano is out of tune. You

> cannot ignore the physical if you want to stay spiritually fresh (Hughes, 2010, p. 1012).

Despite the clear biblical imperative and the ancient self-care examples, international works present an argument for significant multifaceted ill-health in practicing clergy (Cowper, 2012; Lifeway Research, 2015; Proeschold-Bell & LeGrand, 2010; WesPath Benefits / Investments, 2015; 2017; 2019). There appears a prominent disconnect between key theology and practice in clergy self-care which requires further investigation.

1.3 Key Terms and Occupational Context

This section comprises key terms pertaining to the research topic and cohort under investigation, aiming to contextualise the work.

1.3.1 Common Titles of a Christian Church Leader

UK Christian church leaders can be identified under several titles, commonly, Reverend, Minister, Pastor, Vicar, Chaplain, Brother, Rector, Preacher, Clergy/person/man/woman, Cleric and Padre. All titles include male and female practitioners. As different denominations and practitioners can use different titles both within and across denominations, for clarity within this thesis, the broad term *clergy* will be applied to all participants. Clergy has been selected due to its generalised use within the English language to denote religious leadership. This term is used to define practitioners where formal Christian church leadership is their primary job role. ‘Church’, in Christian biblical terms, refers to the people, not the building (Ephesians 1:22-23, New Revised Standard Version Bible: Anglicised, 1989/2017). Ergo, churches may convene in unlikely settings such as cafes, pubs, hospitals, or army camps, among others.

1.3.2 The Demands of a Christian Church Leader – The Great Commission

Before the formal development of the church, Jesus set out clear principles for all Christ followers. This is often referred to as the Great Commission:

> And Jesus came and said to them, 'All authority in heaven and on earth has been given to me. Go therefore and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, and teaching them to obey everything that I have commanded you. And remember, I am with you always, to the end of the age' (Matthew 28:18-20, New Revised Standard Version Bible: Anglicised, 1989/2017).

This directive is often put at the centre of Christian life. For Christian leaders however, the Great Commission is at the centre of a unique, complex, multifaceted, and often demanding role. Leadership requirements have moved far beyond the perceived Sunday sermons and leisurely pastoral visits. A typical minister's job description includes the expected personal Christian skills, practices, and attributes such as a sound knowledge of the bible, prayer life and spiritual growth (Baptists Together, 2011). However, although not demanded, there is an expectation that a leader will also engage in community outreach activities, be a team leader, mentor and educator, counsellor, events manager, director of communications and safeguarding lead. Some roles also require a basic knowledge of building and construction for maintenance and upkeep of the church, as well as an array of other 'key skills' (Andover Baptist Church, n.d.; Blackburn Baptist Church, n.d.; Church of the Nazarene, 2017; Edmondson, 2015; Heaton Baptist Church, 2017; Oakham Baptist Church, 2019). Additionally, some ministers are bi-vocational, engaging in

the aforementioned activities alongside a secondary role (Beverley Baptist Church, n.d.; OSCAR, 2024).

Within the Baptist denomination, the primary role of a minister is to have an unencumbered deep relationship with God, to share that relationship with others, and be an example to the church and local community of Christ centred living (Baptists Together, 2011). The specific ministerial demands on clergy (including hours, skills, and necessary availability) however, are vague when considering denominational guidelines and available job descriptions. For example, the Baptist guidelines for ministry state that ministers should maintain a level of "availability", which relates to the role moving beyond a nine-to-five job to a "way of life" (Baptists Together, 2011, p. 3). Although the guidance does not set out specific hours, nor does it advocate for unreasonable working hours, this lack of specificity leaves ministers in a potentially vulnerable position. What one minister may view as an optional add on to their role, e.g., attending an evening house group, another may view as essential, being a sanctified example to their church congregation. Although on a whole clergy research is sparse, international trans-denominational figures show many ministers succumbing to physical and mental ill-health, with health profiles falling short against comparative adult populations (Cowper, 2012; Lifeway Research, 2015; Proeschold-Bell & LeGrand, 2010; WesPath Benefits / Investments, 2015; 2017; 2019). As such, within the Baptist context, it is worth investigating if elements such as role ambiguity, or absence of clear self-care guidelines / policy, influence individual self-care behaviours.

1.3.3 Rationale for Selecting the Baptist Denomination – Size, Scope, and Place of the Baptist Church in UK Christianity

International published research relating to clergy health is sparse and mainly limited to the Methodist and Anglican denominations. Prominent works have been conducted by US Methodist researcher Rae Jean Proeschold-Bell (Duke University, 2018) who leads one of the only research groups to comprehensively examine Methodist clergy health. UK Anglican researcher, The Reverend Canon Professor, Leslie J. Francis (Warwick University, 2024) has extensively explored only the psychological component of clergy health. As such, UK clergy holistic health research is scant and limited to select denominations.

1.3.3.1 Historical Formation of Protestant Christianity and Denomination Comparison.

To appreciate how the Baptist denomination may compare with the Anglican and Methodist denominations (where the primary body of published works reside) it is useful to briefly explore the history and formation of Protestant faith. In 1517 Martin Luther, a German monk and theologian, began a dispute with the Roman Catholic Church. He challenged key issues in the church hierarchy, transubstantiation observance, and most importantly, how one may obtain salvation, not by works as believed in the Catholic Church (Hillerbrand, 2019). This was a major turning point in the Christian Church known as The Reformation, out of which the western Protestant church was born.

Some western Christian denominations differ on beliefs and practices such as the transubstantiation, modern day saints, prayer to the saints, set liturgy and the place of Mary (mother of Jesus). Others differ on more critical elements such as the

trinity, namely the place of Jesus the Christ within this. Those who observe the triune God, God in three entities, Father in heaven, Holy Spirit to intercede, and Son, God in flesh, living sacrifice, go by the title *trinitarian* denominations.

To accurately compare the research from more than one Christian denomination (e.g., Baptists to Anglicans) it is essential that they share some similar occupational demands, and the same (or very similar) doctrinal views which often drive occupational and life practices. Despite the similarities in doctrine and worshipful practices, the Church of England does have vastly different organisational and operational structures to other UK denominations e.g., finance. Although not employers, the Church of England does pay clergy and lay workers a stipend (The Church of England, n.d.-a). This is not the case for other denominations such as the Baptists, which are self-governing and operate as independent businesses responsible for their own income and salary (Baptists Together, n.d.-c). However, as both Anglican communion and Methodist denomination (in which the existing body of research is orientated) are trinitarian Protestant, it is useful to analyse further Protestant trinitarian denominations.

1.3.3.2 Size and Scope of the Baptist Denomination.

In the 2011 census, approximately 59% of the UK population self-defined as Christian (Religion Media Centre, 2018). The largest UK Protestant Christian trinitarian denomination is the Anglican communion (Church of England or C of E). This is followed by the Baptist church, Methodists, Presbyterians and Congregationalists and the Charismatics and Pentecostals (Religion Media Centre, 2018). The second largest Christian denomination in the UK is the Roman Catholic church (Religion Media Centre, 2018). The Catholic church, however, has significantly differing operational and doctrinal structures to Protestant

denominations as explored in Chapter two. After the Anglican and Roman Catholic church, the Baptist church, one of the largest denominations globally, has had the third largest church attendance in the UK since 1980 (Faith Survey, 2022). Figures from 2021 show the Baptist church has 1,931 UK churches, with 105,277 adult members, 47,335 child members and 22,093 youth members, including many more informal attendees (Baptists Together, 2021a). The Baptist Union of Great Britain (BUGB) which serves as a support agency to UK Baptist churches and training colleges, has several categories of recognition and accreditation (Baptists Together, n.d.-b). Upon personal discussion with the BUGB, the current publicly available listings in these categories do not provide an accurate and up to date picture of active ministers, many of those who retain accreditation are, for example, retired. It was stated that the BUGB has an estimated 1,400 accredited UK Baptist clergy (T. Fergusson, personal communication, October 6, 2021). Some of these may be current active church leaders fitting the clergy inclusion criteria of this thesis, or more general church / community workers e.g., evangelists. Further to this, there are approximately 600 clergy who choose not to seek BUGB accreditation (T. Fergusson, personal communication, October 6, 2021).

1.3.4 Holistic Health, and Wellbeing

Within the nursing model of health, a *holistic* approach is often applied, that is, a consideration of the *whole* of the individual, not merely a focus on the presenting medical issue. Within the National Health Service (NHS) this most commonly includes physical, mental (emotional), spiritual and social health (National Institute for Health and Care Excellence [NICE], 2019; NHS, 2019). The optimum desired state of health therefore, being a harmonious relationship between

the factors (Journal of Holistic Nursing, 2019). Other health models, such as the socioecological approach, include further facets such as financial, environmental, cultural, occupational, intellectual health and more (Khenti et al., 2015; Kilanowski, 2017; Proeschold-Bell et al., 2011; Roger Williams University, 2019).

Holistic health is important in the context of influencing behaviour change or the analysis of illness. Without considering the impact of an individual's complete, holistic health, a comprehensive picture cannot be obtained, and thus interventions may be ineffectual. Current research, from a variety of disciplines, indicates a substantial significant linkage between the health facets (Hamer et al., 2009; Koenig, 2012; Ohrnberger et al., 2017). Psychoneuroimmunological works for example suggest mental health, specifically psychological distress, impacts the immune response to the degree of influencing pain response, mood, neuroendocrine function, and morbidity (Antoni, 2003; Cummings & Pargament, 2010). Separating the health facets during the patient journey, such as physical health and spirituality, is a recent western phenomenon, and has potentially detrimental effects to patient outcomes (Koenig, 2012). Considering holism in workplace health and occupational psychology therefore, allies with the contemporary US "Total Worker Health" method. The premise being that most workers spend more than half of their lives in the work environment, as such, this environment should protect and promote health (Adams, 2019).

Within this thesis a holistic understanding of health will be used. The exact facets under investigation, where necessary, are detailed. A pragmatic approach to the selection of the facets under investigation has been taken in line with other prominent clergy and occupational health research. It is, however, understood, that holistic health is extremely broad and comprises many facets that may affect health.

Distinct from health, the term ‘wellbeing’ will also be used throughout this thesis. Although no singular definition exists, wellbeing is understood in the UK to encompass an individual’s thoughts and feelings about themselves and their lives, this includes their purpose and satisfaction (Department of Health, 2013; NHS Digital, 2022; What Works Wellbeing, 2014). Wellbeing is included, as it differs from illness (or objective health measurements) and considers the subjective positive factors that promote personal flourishing, indicative of personal resilience and resources.

1.3.5 Religious Coping

It is suggested that negative factors in demanding roles such as ministry are somewhat moderated by religiosity, religious coping methods, and work sanctification which may promote positive health outcomes (Backus, 2013; Pargament et al., 2000). Religious coping is defined as the religious drivers, frameworks, and sacred practices that an individual may physically and emotionally employ (actively or passively) when reacting to an event (Cummings & Pargament, 2010). Religious coping can offer a sense of power to persevere or accept the situation (Cummings & Pargament, 2010). Additionally, religious coping can offer a sense of understanding to the extreme challenges of daily life, thus perpetuating meaning in otherwise distressing personal scenarios (Wortmann, 2013). It can instil the believer with essential tools in any given situation, such as the fruits of the spirit (patience, kindness, joy, peace, self-control, etc. [Galatians 5:22-23, New Revised Standard Version Bible: Anglicised, 1989/2017]) as well as closeness with God, the self, and others (Wortmann, 2013). As such, when used alongside other personal

holistic health and wellbeing tools and skills, religious coping may be perceived as a positive personal coping strategy.

When theories surrounding work outcomes and religious practice are cross-referenced with contemporary neurobiology, a distinct picture of the interrelationship between spirituality and health develops. The quantifiable impact of religious coping can be appreciated from a neurotheological approach. Neurotheologists such as Newberg (Tedx Talks, 2016) present a clear connection between neurological functioning and religious practices. Newberg's work shows quantifiable changes in chemical output and brainwave function when a participant engages in prayer or meditation. Although more research is needed in this area, this correlates with current research on the religious coping phenomena. For example, patients with coronary heart disease (CHD) who prayed have had fewer post-operative complications, similarly, prayerful groups of HIV positive patients showed improved blood counts and longer five-year survival rates (Cummings & Pargament, 2010). Due to these known phenomena, The World Health Organisation (WHO) and the World Psychiatric Association have produced a position statement detailing the necessity for mental health professionals to recognise the impact of religion and spirituality in treatment protocols (Moreira-Almeida et al., 2016). Referencing over 3,000 empirical studies, the statement suggests that this often-overlooked component of health can be a significant influencing factor in patient outcomes, quality of life and wellbeing.

Religious coping however, does have a less desirable side. As stated in Cummings and Pargament's (2010) work, it is paramount to discern the intention behind the application of the sacred practice, such as prayer, and its content. For example, clergy may pray through a particularly difficult period of work, for strength

and endurance in their calling and vocation. This is not to dispute the power of God to uplift and fortify the individual, however, in doing so, some level of justification of the stressor is sought. In patients with chronic or life-threatening illness, this stressor justification (e.g., I am being tested, moulded or punished) can lead to negative mental and physical health outcomes (Cummings & Pargament, 2010). In the context of clergy experiencing work-related health issues, they may for example, seek inner change (strength and endurance) instead of seeking practical steps to offer a sustainable healthful occupational improvement. Therefore, in the context of this thesis, spirituality, how it is used, and the potential positive and negative effects on clergy will be considered.

1.3.6 Burnout

In the 1970s, clinical burnout was described as a phenomenon with physical and behavioural symptoms that those in the caring professions were often subject to (Freudenberger, 1974). As research on the subject has developed, the consensus emerged that burnout is no longer limited to specific occupations. Burnout is now recognised in all professions where workers may be subject to emotional and mental exhaustion resulting from work activities (Iacovides et al., 2003). One may be *called*, or receive substantial fulfilment in their job role, however, if the appropriate measures are not put in place, such as rest, reflection, and recreation etc. burnout may occur. Clergy, therefore, who for multifactorial reasons invest significant amounts of time, energy, and both physical and mental effort without stopping to *refuel*, may be susceptible to burnout (Rolph & Rolph, 2008). When exploring Freudenberger's (1974) seminal early work on burnout, in the section "Who is prone to burnout", the descriptors could easily be referencing clergy:

> The dedicated and the committed. Now that may sound foolish. But just think for a minute. Those of us who work in free clinics, therapeutic communities, hot lines, crisis intervention centers, women's clinics, gay centers, runaway houses, are people who are seeking to respond to the recognized needs of people. We would rather put up than shut up. And what we put up is our talents, our skills, we put in long hours with a bare minimum of financial compensation. But it is precisely because we are dedicated that we walk into a burn-out trap. We work too much, too long and too intensely. We feel a pressure from within to work and help and we feel a pressure from the outside to give. When the staff member then feels an additional pressure from the administrator to give even more, he is under a three-pronged attack. (Freudenberger, 1974, p. 161)

Contemporary works on denomination specific clergy burnout (Adams et al., 2017; Miner, 2007; Rolph & Rolph, 2008) indicate a significant issue within this occupational group which requires further research. As such, this thesis aims to examine burnout risk as part of a health profile.

1.3.7 Self-care, the Benefits, and Importance

The WHO defines self-care as, "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare worker" (WHO, 2019, para. 1). This encompasses many factors and practices including but not limited to, nutrition, exercise, general health and hygiene, living conditions, social factors, beliefs both religious and cultural, as well as finance (WHO, 2019). It is widely accepted that self-care practices, however far apart they may appear from the

stressor itself, can significantly positively alter neurological and biological processes underpinning positive holistic health (Alexander et al., 2015; Beresin et al., 2016; NHS, 2018; NICE, 2018; Lee, & Miller, 2013). Acute stress for example, is known to flood the brain with dopamine (similar to illicit drugs and alcohol). Although dopamine produces health in our brains, too much can inhibit rational thought processes and impair judgement (MHFA [Mental Health First Aid] England, 2019). A calm mind (one which is not flooded with stress related neurochemicals) is widely known to increase a person's reasoning ability, allowing them to strategize reasonable logical solutions to life's issues (MHFA England, 2019). These positive physiological effects further promote resilience (a learnable skill [Beresin et al., 2016]) whereby an individual may increase their coping ability by drawing on supportive mechanisms e.g., mindfulness.

Due to the unique nature of ministry and the many known facets of the vocation, parallels can be drawn between many professions, most notably that of counsellor. In an article on the ethical, but often neglected, imperative of self-care in the role of the clinical psychologist, Barnett et al. (2007, p. 609) highlight the critical importance of the "person" in the role. The person themselves being a vital instrument in practice, with the individual skills of the person potentially determining the success of the therapeutic exchange. Going so far as to suggest skills such as decision making, capacity to reflect, wisdom and general self-care collectively impacting the competence of the practitioner (Barnett et al., 2007). In the case of clergy therefore, the mental and physical health outcomes of parishioners may be significantly influenced by clergy's counsel. The person of the clergy, therefore, is an essential instrument in the counselling exchange, and thus dependent,

at least in part, on their self-care ability. As such, this creates a further rationale to explore the self-care practices of this occupational group.

The WHO states that self-care principles are individual to the person (e.g., diet and socialisation) but also suggest major influences from outside the self, in the greater community (WHO, 2019). In the context of clergy barriers and facilitators to self-care, it is important to consider the impact of these influences on health behaviours. Clergy's decision making and practice are influenced by many factors, with a primary factor being their interpretation (denomination dependant) of scripture and relationship with God. Influence also comes from working as office holders, as respected figures in community, as parents, husbands, and wives, as members of their specific geographical community and their individual personality traits (Dankasa, 2015; Francis & Rodger, 1994; Harmon et al., 2018). What factors commonly influence self-care practices in Baptist clergy will be examined in this thesis.

1.3.8 The Christian Context of Holiness and the Self-care Movement

Christians are called to be holy "in *all* they do" (1 Peter 1:14-16, New Revised Standard Version Bible: Anglicised, 1989/2017) "word and *deed*" (Colossians 3:17, New Revised Standard Version Bible: Anglicised, 1989/2017). Many somewhat cherry-pick these verses to be outward expressions of faith in how they interact with others (e.g., care, respect, dignity, honesty etc.) overlooking self-care in the treatment of God's gift of the body. In doing so it can be observed, both anecdotally and in the international literature, clergy experiencing burnout, obesity, hypertension, stress, depression, CHD, and other serious physical and mental health

issues (Cowper, 2012; Lifeway Research, 2015; Proeschold-Bell & LeGrand, 2010; WesPath Benefits / Investments, 2015; 2017; 2019).

The word ‘holy’ is used in many world religions, each with a slightly different view on its origin and meaning. The word holy in the original Hebrew is ‘qadosh’, meaning to be set apart, different from the norm, righteous and sacred. The English word holy derives from the Anglo-Saxon word ‘hălig’, from the Germanic Dutch influence ‘heilig’, in literal terms meaning well or whole. As humans encompass a mind, body, and spirit which make us unique individuals, to be *holy* in Christian terms therefore, one must be indeed set apart, righteous in spirit, but also whole and well in our person. This set-apartedness can arguably be applied to holistic care of the body, including abstinence from harmful practices and the inclusion of fortifying strategies, religious and otherwise.

Holistic self-care in some Christian circles has coined the phrase ‘The self-care movement’. A somewhat derogatory term whereby a number of Christian influencers, including some clergy, are voicing their reluctance to holistic self-care, deeming the practice inward looking, self-serving and ultimately not kingdom focussed (Fuller, 2018). Some of the negativity appears to stem from a critical misunderstanding of self-care. Some writers are voicing their concerns by viewing essential practices (e.g., me-time, stress management strategies, and breaks) as seeking life’s answers by looking inward (instead of upward) (Brownback, 2019; Liu, 2019; Segal, 2016). Some stating some aspects of self-care are “Practicing forgetfulness, rather than pursuing forgiveness.” (Segal, 2016, para. 5) and “…plain old self-indulgence.” (Brownback, 2019, para. 1). However, in the context of holiness, it could be argued that one cannot be fully whole when all focus is on

spirituality alone, and the vessel (the body) which holds the means of spirituality (our souls and minds) is neglected.

This is not to suggest that care of the body cannot be done in a worshipful fashion as it is said “So whether you eat or drink or whatever you do, do it all to the glory of God.” (1 Corinthians 10:31, New Revised Standard Version Bible: Anglicised, 1989/2017). All Christians (including those who are differently-abled) are called to protect and promote their gifts (physical, mental, and spiritual etc.) in their entirety for the glory of God (Matthew 25:14-30, New Revised Standard Version Bible: Anglicised, 1989/2017). With reference to clergy self-care therefore, this means utilising the known positive and beneficial tools (e.g., exercise and mindfulness) in a Christ centred fashion, to promote healthy holistic functioning, and by extension the fullest expression of their gifts. This thesis, therefore, aims to explore some of the common barriers and facilitators to self-care which includes beliefs which may promote or hinder action.

1.3.9 Workplace Wellbeing

The International Labour Organization (ILO) (2020) describes workplace wellbeing as including all aspects of working life. This includes basic health and safety, perceptions about the work itself, suitability of the work environment, as well as organisational and hierarchical functionality. The goal of effective wellbeing interventions being to promote better engagement in the work, and healthy, fulfilled workers. Additionally, ILO (2020) state that a lack of attention to the wellbeing needs of workers can lead to significant physical, interpersonal, and psychological health issues. It is apparent from several robust health, safety, and support networks that wellbeing at work is paramount not only to longevity of the individual in post,

but to the effective functioning of any business (Advisory, Conciliation and Arbitration Service [ACAS], 2012; International Labour Organization [ILO], 2009; The Chartered Institute of Personnel and Development, 2019; The Institution of Occupational Safety and Health [IOSH], 2015). It could be argued that a church where its clergy are burnt-out, overstretched, or experiencing holistic health issues, and thus unable to meet the needs of the community, has become ineffectual. Therefore, as US clergy research indicate symptoms of work related physical and mental distress, and there is scant UK research, further investigation into UK clergy holistic health, self-care, and perceptions of support is warranted.

1.4 Chapter Conclusion

The understanding of clergy self-care perspectives, role demands, holiness, theological context, religious coping, and other key terms provide an essential foundation to this thesis' investigations. These factors not only assist in reader comprehension of the works, but also direct study design in the maintenance of theological and cohort specific sensitivity. In the context of UK Baptist clergy, their job demands, alongside inter and intrapersonal coping tools, are important considerations in research design, including interventions. Attitudes, barriers, and facilitators to self-care will be explored in this thesis.

Chapter 2: Mapping Literature Review, Key Findings

2.1 Introduction

The previous chapter examined some of the biblical drivers for self-care and the potential demands on clergy, given their broad role descriptions. This chapter presents a further rationale for additional clergy occupational psychology research by exploring pertinent UK and international clergy works. This chapter presents a mapping literature review offering a critical summary of current clergy health and wellbeing research, highlighting strengths, limitations, and gaps in the research field. The chapter concludes by summarising what is known alongside the significant current gaps in Baptist clergy research. The findings of this chapter present a critical foundation and rationale for this thesis' investigations.

2.2 Method

2.2.1 Research Questions

The following research questions were explored in the current review:

1. What is known regarding the current occupational health and wellbeing status of UK Baptist clergy?
2. What gaps are present in the UK research pertaining to UK Baptist clergy occupational health and wellbeing?

2.2.2 Mapping Review

A mapping review methodology was selected as a suitable strategy to explore the current gaps in the research field. Mapping reviews are suitable for categorising theoretical approaches and highlighting gaps in the existing literature as a starting

point for primary research where in-depth analysis is not required (Grant & Booth, 2009; Khalil & Tricco, 2022).

An initial search matrix (Appendix A) was followed using the basic search concept ‘clergy holistic health behaviours, barriers and facilitators’ considering synonyms, broader and narrower terms, related terms, truncation, alternative spellings and variants. Using this framework, NUsearch (The University of Nottingham library database [The University of Nottingham, n.d.-c]) was searched to identify works in the UK and internationally.

2.2.3 Exclusion of Catholic Leaders

There exists several significant differences between Catholic and Protestant church leadership. These differences are such that despite potentially similar congregational challenges, the religious observance, operational, organisational, and support structures create significant distinctions (Del Rosario, 2014). Evidence indicates that Protestants and Catholics may also fundamentally differ on social ethics and psychological factors such as guilt (Arruñada, 2010; Sheldon, 2006). Catholic life expectations (such as celibacy, female clergy, and the hierarchical priesthood) response routes to daily challenges (such as confession, and prayer to the saints) and The Sacrament of Holy Orders, fundamentally distinguish Catholic and Protestant clergy. Although both may feel their vocation is a calling, Protestant clergy do not observe ministry as a sacrament or as having any higher authority (Signalness, 2016). The literature also points towards significant occupational wellbeing differences, where Protestant clergy have presented with higher levels of work-related stress than Catholic priests and nuns (Weaver et al., 2002, p. 393). Due

to these significant lifestyle, occupational, sacramental, and doctrinal differences, Catholic research was not explored in this thesis.

2.2.4 UK Research Limitations and Review Sequence

The following provides a mapping review of the current, to date, cross-denominational published data, and relevant unpublished evidence. Due to the limited number and scope of UK publications, this literature review will take a sequential approach, identifying UK clergy projects closest to this thesis' aims and goals (many unpublished) then moving on to consider other UK published work, and finally exploring the international literature. The number and type of retrievals can be viewed in Table 2. Summaries will be given at the end of each section to highlight key factors and their relevance to this thesis' research.

Table 2
Identified Literature

Type of item	Country of origin	Number of items included for review
Journals	UK	30
Journals	USA	25
Journals	Australia	5
Journals	Other international	3
Internal reports and projects	UK	3
Internal reports and projects	USA	4
Dissertations and theses	UK	1
Dissertations and theses	USA	7
Dissertations and theses	Other international	1
Total number of items included	Journals	63
	Internal reports and projects	7
	Dissertations and theses	9
	Overall total of works included	79

2.3 UK Findings – Internal Church of England Works

The largest UK denomination, the Church of England, have conducted several internal works that were not published in the peer reviewed literature. These works were explored to ascertain a broad picture of contemporary UK clergy health and wellbeing, as well as the prevalence of research, preferred methodologies and approaches, and result dissemination methods.

2.3.1 The Church of England Living Ministry Programme

The main body of UK clergy published and internal research to date, appears limited to the Anglican (Church of England) communion. The denomination website provides unpublished health and wellbeing documents informed by a longitudinal mixed methods investigation, The Living Ministry Programme (The Church of England, n.d.-b). The Living Ministry Programme is the most comprehensive clergy holistic health and wellbeing investigation in the UK. It is unclear however, given the in-depth, valuable insights that this work offers, why this data has not (and will not be [L. Graveling, personal communication, October 17, 2022]) published in peer-reviewed journals for wider academic benefit. Although unpublished, the phased study provides an in-depth exploration into clergy wellbeing and ministerial outcomes (effectiveness) (The Church of England, n.d.-c, para. 4). The mixed methods project, (spanning 2016 to 2026) thus far has explored the mental, physical, financial, relationship, participatory, spiritual and vocational health facets (Graveling, n.d.). Results indicate positive self-rated wellbeing decreasing across the age groups, 89.7% of respondents in the under 31 group indicated good or excellent health, this reduced to 81.9% of the 32-54 group, and 77.7% in the 55 and over group (Graveling, 2018b). This may be a result of natural aging, age related health concerns, and reduced energy levels etc. however, the work did indicate some concerns with boundaries, demands, and relationships. Twenty six percent of respondents felt isolated in their roles, 22% stated they did not take a full day off each week, and 81% stated they were unable to mentally detach from work more than once weekly (Graveling, n.d.; Graveling, 2018b). Quotes from the qualitative sections indicated further concerns, particularly in job demands and the social health domain:

"You can have friends, but you have to be very careful about it" (Graveling, 2018a, p. 54).

"I have a lot of difficulty determining what is work and what is friendship. … so, day off, somebody phones you, is that work or is that friendship if they are in trouble" (Graveling, 2018a, p. 54).

"I'm never really off, I think that's the thing, you're never really on leave if you're in the vicarage" (Graveling, 2018a, p. 32).

> I do continually recognise the impossibility of the job and have to keep saying, okay Lord, what do you want me to focus on? Because if I try and do everything and I try to meet everyone's expectations I will just not be able to cope mentally" (Graveling, 2018a, p. 32).

These results raise questions regarding the health and wellbeing demands resulting from the role, particularly given the reducing self-rated wellbeing scores across the age groups. Ultimately, can clergy effectively sustain the 'always on' nature of the role combined with few social outlets (or complex social lives) without this having a detrimental effect on other holistic health facets? Notably, however, the research did highlight positive outlets and strategies for self-care, with some clergy citing the place of open communication, boundary setting, diet and exercise, books, courses and resources, and holidays (Graveling, n.d.). In relation to this thesis, it is not known whether this research is reflective of other trinitarian denominations, such as Baptists.

2.3.2 The Church of England Covenant

In addition to The Living Ministry Programme (The Church of England, n.d.-b) the Church of England published a covenant born out of several years of internal

surveys, focus groups, and Francis et al.'s (see section 2.4) published works (Clift, 2018). The "Covenant for Clergy Care and Wellbeing" acknowledges that clergy in the Church of England require support with their ministerial calling, and their personal and professional wellbeing (Butler, 2019; Cantuar, & Ebor, 2020).

The covenant states:

> Conscious that such a calling is both a privilege and a demand, we commit together to promote the welfare of our clergy and their households.
>
> We undertake to work together to coordinate and improve our approach to clergy care and wellbeing so that the whole Church may flourish in the service of the mission of God (Butler, 2019, p. 15).

This covenant, and its aligning resources, provide practical support for clergy as they navigate their calling, and encourage clergy in post to seriously consider the place of self-care in their daily lives (The Church of England, 2020; The Church of England, 2019b). This is indicative of the contemporary necessary nature of clergy self-care health promotion activities, providing a further rationale for this thesis' works. Indeed Butler (head of the covenant working group) stated, "Our vision is that the work of supporting clergy in their ministry will become an integral part of the life of the Church and part of the DNA of every aspect of our mission and ministry" (Butler, 2020, para. 1).

The synod summary paper sets out five notable goals:

1. A shift towards the preventative
2. A shift towards mutual responsibility
3. A shift towards a coordinated response
4. Culture change
5. Achievability (Butler, 2019, pp. 5-6)

It is noted that the Church of England operates differently to many independent Baptist churches, and as such resides under different legal obligations. That said, this is an example of a strategic approach to clergy welfare that surpasses legal obligation, to moral Christian duty, of which Baptist churches, and support agencies, are bound.

2.3.2.1 Terminology.

Covenant – a formal agreement or promise often including a relational element to the commitment, e.g., between God and humans (The Baptist Union of Great Britain, 1999). This word is not used lightly and is an important feature in determining the seriousness of the Church of England's stance on clergy wellbeing, and the place of clergy wellbeing in modern ministry.

Synod – an ecclesiastical term used by Christian denominations where a council (usually of elders) are convened to discuss important issues relating to the life, work, and doctrine of the church (The Church of England, n.d.-d). Again, the convening of a synod to contemplate and debate the place of clergy wellbeing at the highest of levels, indicates the significance and place of clergy wellbeing in modern Protestant culture.

2.3.3 The Church of England - Experiences of Ministry Project

Partnering with King's College London and Royal Holloway University, The Experiences of Ministry Project set out to investigate "…what best supports and sustains the well-being and effectiveness of priests within the Church of England" (King's College London, n.d., para. 1). The project ran from 2011 to 2017, capturing the opinions of over 6,000 Church of England clergy (Clinton & Ling, 2017). Results suggest that those with a sense of purpose through their work were more

likely to thrive (Clinton & Ling, 2017). Diary data collected from 900 clergy regarding their calling suggests that although intense calling may have positives, it may also lead to longer working hours, reduced ability to switch off on leisure time, and subsequent reduced sleep quality and refreshment (Clinton et al., 2017). The report, overall, implied that clergy wellbeing was comparative to other occupational groups, however, those who were unable to cope did so due to a demands-resources imbalance and / or sacrificing their personal wellbeing (Clinton & Ling, 2017).

This project, however, did not examine other intrinsic contributing factors to either ministerial flourishing or burnout. The report suggests wellbeing was examined using the psychological domain only, considering two dimensions of burnout coupled with psychological detachment (Clinton & Frasca, 2017). It appears that the concept of 'wellbeing' in this project (unlike the living ministry programme) was focussed on psychological factors alone, neglecting the potential impact of the broader spectrum of wellbeing.

2.3.4 Ill-defined Wellbeing

Wellbeing is an umbrella term that is defined slightly differently across organisations and institutes. The consensus within the NHS and UK government, however, is that wellbeing is in fact holistic, incorporating (but not limited to) dimensions of social, financial, physical, mental / emotional, and occupational health (Care Act 2014, 2014; NHS, n.d.-a; NHS Hertfordshire Partnership University, 2017). In relation to the previous investigation therefore, wellbeing does encompass the mental and emotional health domains, however, it may be impacted or influenced by the other health facets (Care Act 2014, 2014; NHS Hertfordshire Partnership University, 2017). It would have been advantageous to explore the other influencing

facets of holistic health alongside the presented psychological components. This may have aided in gaining a deeper understanding of the occupational biopsychosocial impact on clergy, further informing future interventions and research.

Notably, despite being carried out in the same denomination, the previous two works appear to approach wellbeing quite differently. The Living Ministry Programme highlights the necessity to further explore the interconnected nature of the holistic health facets (Graveling, 2018b) identifying that wellbeing in the clergy context comprises four factors:

1. Wellbeing is varied
2. Wellbeing is holistic
3. Wellbeing is negotiated
4. Wellbeing is the responsibility of multiple actors (Graveling, n.d., slide 5).

Considering the place and purpose of clergy wellbeing identified in this denomination, it may be advantageous therefore, to have a common denomination specific definition of wellbeing. This may prevent ambiguity in the understanding of holistic wellbeing in policy and research, such as the discrepancy between the previous two projects. The works carried out in this thesis, therefore, would align with Graveling's (n.d., slide 5) definition. Following their example, clear descriptors of holism and wellbeing, as used in this thesis projects, have been provided from the outset (Chapter one).

2.3.5 Experiences of Ministry Project – Diocese of Sheffield Pilot

The Experiences of Ministry Project's internal and published outputs (Clinton et al., 2017; Clinton & Frasca, 2017; Conway et al., 2015; Sturges et al.,

2019) were used to underpin an internal support project for ministers piloted in the Diocese of Sheffield (The Diocese of Sheffield, n.d.). This project focused heavily on occupational resources to support ministers (e.g., administrative assistance) to amend demands-resource imbalance. Despite the positive support nature of the project, the interventions proposed do not appear to support wellbeing in the holistic sense (The Diocese of Sheffield, 2014). The six-year project used a one-million-pound grant to focus support on the reduction of clergy administration and 'paperwork' tasks by employing 14 'Mission Partnership Development Workers' to work across four parishes (Millar, 2017; The Diocese of Sheffield, n.d.; 2014). The aim being to support individual churches to become more self-sufficient in growth, congregant gift development, and finance, freeing up ministers to attend to more clergy role specific tasks i.e., Christian 'mission' (Millar, 2017). What is questionably sustainable, however, is the demands shift on some clergy. Examples given on the project website suggest clergy are freeing up time to offer to other tasks e.g., developing links with local credit unions (Millar, 2016, para. 8). Although this is likely welcomed by congregants, replacing one demand (e.g., administrative tasks) with other demanding projects, does not appear to be a sustainable approach in supporting clergy holistic wellbeing as per the Living Ministry project's definition (Graveling, n.d., slide 5; Seeley, 2018, p. 3). In considering the demands-resources imbalance, the project does appear to offer support to increase personal resources, however, if these resources are then being applied to other occupational demands, the imbalance would theoretically not be appropriately restored. The initial documentation indicates that a goal of the project is to become sustainable beyond the six-year period (Millar, 2017) however, from the publicly available documentation it is unclear if the project has or will reach that goal, or if the project

has sustainably impacted clergy occupational wellbeing. As of Autumn 2024, there are no publicly available updates, data or conclusions relating to this project. Additionally, there is no further mention of Mission Partnership Development Workers on the diocese website, suggesting the project has now ended.

2.3.6 The Church of England - Diocese of Ely

The Church of England have other internal research, longitudinal investigations, and interventions ongoing. One five-year investigation took place in the Diocese of Ely (Wyatt et al., 2017). This investigation appeared to have a denominational health driver, i.e., healthier ministers equate to a healthier church. The diocese attempted to identify areas of challenge or difficulty that specifically impacted personal or professional wellbeing (Wyatt et al., 2017). The five-year investigation's results indicated clergy needed role change, development, or clarity in the areas of professional relationships, communication, and workload (Wyatt et al., 2017). The 2019 report stated that 40% of the 96 respondents chose the word 'weary', to describe their current state of wellbeing (38% in the 2016 survey) (Wyatt et al., 2019). It also showed an increase in the number of clergy missing days off and taking time in lieu (37.5% in 2016 to 45.8% in 2019) (Wyatt et al., 2019). Despite the smaller number of respondents in this investigation, the data adds to the overall picture of clergy health in the Church of England. The questionnaire explored some facets of wellbeing including self-rated emotional health, outlets, and professional flourishing; however, it does not appear to be as holistically comprehensive as Graveling's (2018a; 2018b) work. This again highlights an internal issue of research sharing, dissemination, and clear professional definitions (e.g., wellbeing) in the denomination.

2.3.7 UK Internal Works Conclusion

The available internal works suggest a core of established internal research and investigation teams within the Church of England. Given the methodology, core definitions, and publication disparities, however, there does appear a disconnect between the teams, in their approaches to results translation, and information dissemination. When considering real-world impactful research, it would be advantageous to have common objectives, themes, definitions, and processes within a singular denomination. This approach may aid in the often-sequential nature of research, building from one study to the next, and implementing recommendations into clergy daily practice.

The evidence in these works indicate that clergy participants have a high workload (Wyatt et al., 2017; 2019) long working hours (Graveling, 2018b; Wyatt et al., 2017; 2019) and complex professional and personal relationships (Graveling, 2018a; Wyatt et al., 2017; 2019). In the context of this thesis, it would be useful therefore to explore some of these factors within the Baptist denomination.

2.4 UK Publications - Francis et al.

A substantial body of UK research features the same author, Francis. These works primarily focus on the Anglican communion, with a small number featuring or comparing other UK and international denomination's clergy (Warwick University, 2024). Notably, however, despite the prolific nature of the works, the research appears to concentrate largely on clergy psychological health, type profiling, gender differences, and psychological factors impacting ministry and occupational health / satisfaction. The works, as with some of the other Church of England internal

investigations, do not appear to consider any other influencing, or affected, holistic health facets in-depth.

2.4.1 FPTS

Francis' work in profiling and categorising psychological type in clergy has led to the design and validity testing of the Francis Burnout Inventory (FBI) (Francis et al., 2017b) and the 40-item Francis Psychological Type Scale (FPTS) (Francis et al., 2011a). The scale seeks measurement in the following areas, introversion and extraversion, sensing, intuition, judgment, thinking, feeling, and perceiving (Francis et al., 2017a). Although Francis et al.'s (2008; 2017a; 2017b) works are limited to psychological profiling, they do indicate areas of potential ministerial struggle or poor person fit based on learned or intrinsic personal qualities.

In a study of 1480 Church of England clergy, the FPTS was used to explore characteristics of effective ministry based on innate factors and personal dimensions. Namely, which clergy characteristics help a church thrive and which are linked to church decline (Watt & Voass, 2015). Age was found to be a significant factor, younger clergy self-classifying as innovators with envisioning skills, whereas older clergy were cited as stating they were more persistent (Watt & Voass, 2015). The work overall was inconclusive, in that no specific single or group of personality factors were identified as 'gold standard' for ministry. Indeed, personality traits are somewhat 'combined' to affect, or be effective in ministry (Watt & Voass, 2015). The results do suggest that those clergy who scored high in both extroversion and intuition encapsulated some of the leadership qualities sought in this study (Watt & Voass, 2015). Yet, these traits are not always found in Church of England clergy, who are often defined as introverts (Watt & Voass, 2015). Most notably the study's

conclusion comments on the acquisition of leadership skills, suggesting that the presenting skills of clergy may not always translate into their suitability for ministry, that some skills may be innate, and some may be learned (Watt & Voass, 2015). That learning may also occur by trial and error (a minister stepping into a job out of necessity and rising to the challenge) or be more conservative, through leadership skills courses and training etc. (Watt & Voass, 2015). Although not a specific health and wellbeing study, this investigation, and the works of Francis et al. (2017a) on personality type, may be an indicator of coping ability in the profession or indeed ability to learn self-care skills that may uphold the minister. This is a useful finding in relation to the works of this thesis, particularly when considering the potential openness of Baptist clergy to learn new self-care strategies.

2.4.2 Francis' Work Incorporating Baptist Clergy – Grouping Denominations

In their earlier work on psychological type profiling, Francis et al. (2011b) compared the psychological types of Methodist and Baptist clergy, considering their differences with Anglican clergy. This study is one of two UK articles to date to consider Baptist clergy. This study comprised 80 Baptist and 109 Methodist clergy, and focussed on gender differences, but found few significant results (Francis et al., 2011b). Some differences were found in thinking and feeling components, however, these differences were less pronounced than comparative adult populations (Francis et al., 2011b).

The study groups the Methodist and Baptist clergy under the umbrella term of 'free church ministers', emphasising the differences with Anglicans as opposed to exploring the nuances of individual denominations (Francis et al., 2011b). As the

Methodist and Baptist denominations operate differently, it may have been advantageous to present denomination specific psychological type differences.

The second study to feature Baptist ministers takes the same approach of grouping clergy together, where in a sample of 59 male clergy, 19 were Baptists (Francis & Robbins, 2002). The paper grouped participants together in the conclusion as 'evangelical clergy', claiming specific personality traits, such as attention to detail and adherence to tradition (Francis & Robbins, 2002). The study again, does not consider specific denominational or operational differences that may impact areas such as access to training, skill development, and other supportive strategies, these areas are known to differ trans-denominationally (Watt & Voass, 2015).

2.4.3 FBI

Rooted in Maslach's burnout inventory, Francis' other significant research contribution is the 22-item FBI (Francis, 2017b; Francis et al., 2019; Randall, 2013). The FBI seeks to measure clergy burnout using two domains, assessing "…styled emotional exhaustion in ministry and satisfaction in ministry" (Francis et al., 2017b, p. 119). These two scales exclusively existing in a state comparable to the balanced affect model. The balanced affect model postulates that an individual may perceive high levels of both positive affect (work satisfaction) and negative affect (exhaustion) simultaneously, and it is the difference between the two which may indicate potential psychological disharmony (Bradburn, 1969; Francis et al., 2017b). This concept is rooted in biophysiology and biopsychology in the production and maintenance levels of neurotransmitters such as dopamine (associated with positive affect) and serotonin (associated with negative affect) (Nabi, 2008; Ostir, 2001). The

networks producing these chemicals exist on independent channels, positive and negative affect therefore, existing on separate scales, not, as many perceive, on one continuum (Francis et al., 2017b). Balanced affect author Bradburn (1969, p. 65) stated "Since the two dimensions are independent of one another, knowledge of person's standing on one dimension will not enable us to predict his position on the other." Ergo, presenting an argument for the necessity for holistic assessment in clergy. In the case of clergy therefore, aspects such as work sanctification, value, and satisfaction may be experienced at the same time as one or more negative issues such as compassion fatigue, physical fatigue, and cynicism. The positive affect and the negative affect exist on separate scales, however, the dissonance can indicate potential issues such as burnout perpetuating physical health risk e.g., coronary heart disease and stroke (Bradburn, 1969; Nabi, 2008; Ostir, 2001).

2.4.4 Francis – Lack of Holism

Despite balanced affect theory hinting at holism, Francis' UK work presents little holistic awareness. Turton and Francis (2007) explore the effect of prayer (spiritual health) on burnout findings with positive effects, however, comprehensive holistic assessment is lacking from their work. In a later work with the Presbyterian church in the US, Francis et al. (2013) do attempt to consider coping strategies that may support satisfaction in ministry and prevent emotional exhaustion. Five specific strategies were selected by the church for investigation: "…the provision of sabbaticals, the availability of study leave, the use of a mentor, the use of a spiritual director, and the membership of a minister peer group" (Francis et al., 2013, p. 5). The article does state that other support strategies are available to the individual, however, the investigated factors were selected by the church specifically. Francis et

al. (2013) state that none of the five strategies were shown to reduce work-related burnout or enhance psychological wellbeing. However, in considering the presence of these support factors alone, without exploring their suitability, person fit, or how clergy engage, it is questionable if one can determine that these factors have zero effect on burnout or wellbeing. To gain a true picture of the suitability of these supports, it would be advantageous to further investigate factors such as how often clergy engage, if they are able to make the time amidst busy schedules, do they find the peer groups useful, and do they connect with mentors among others. This raises research reporting concerns, as if these findings are presented to policy makers and church hierarchy, is future support investment likely if these types of supports are presented as ineffective or have little ROI? In this Francis et al. (2013) study, responsible real-world research dissemination is questioned, and the potential for confirmation bias is raised, particularly as this work does not suggest any study limitations.

Notably, Francis appears as a fourth author on a UK United reformed Church's study regarding rural ministries and the benefits of countryside walking as a tool to aid in physical and emotional wellbeing (Rolph et al., 2011b). This appears one of the only papers to consider health from a more holistic perspective, considering facets including physical, mental, and financial. Despite the beneficial nature of countryside walking, this study did indicate significant pressures in this clergy group. Participants exhibited symptoms of poor financial and physical health, and high instances of presenteeism and leavism (Rolph et al., 2011b). These participants were somewhat unable to engage in beneficial activities due to lack of resources (e.g., time, finance, general work pressure). Again, this highlights the necessity for a deeper understanding of the barriers and facilitators to engagement in

healthy, supportive activities, and not taking the somewhat myopic perspective of simple provision, as in Francis et al.'s (2013) work.

2.4.5 Select Health Domains Study

Francis appears again as second author with Rolph et al., (2011a) on a small UK United Reformed Church investigation of 22 female clergy. The study is framed as a health check and states it explores the physical, psychological, religious, and spiritual health domains (Rolph et al., 2011a). With regards to ascertaining a holistic health picture, however, the study is limited. The methodology and sampling procedure are unclear. The response rate is stated as 60%, reporting that 58 questionnaires were returned. It appears, however, that only 22 responses were analysed. The study does not comment on why 36 responses were excluded and does not include a study limitations section to discuss this. The investigation asks about GP contact as a means of gauging the level of individual support (Rolph et al., 2011a). It does not ask or leave space for any other aspects of physical health support e.g., weight management clubs, yoga, acupuncture, alternative therapies etc. The questionnaire did ask an open-ended question regarding what practices clergy engage in to keep themselves healthy. This provoked a variety of responses, from eating a healthy diet to engaging in prayer (Rolph et al., 2011a). The final aspect of determining level of physical health was asking when participants last had their blood pressure checked (Rolph et al., 2011a). This question alone suggests a misunderstanding of this clinical measure i.e., it is pointless having a blood pressure check if no healthy actions follow. Participants' subsequent response to blood pressure analysis was not requested or discussed. GP contact and blood pressure

analysis are insufficient elements, in isolation, to determine true levels of physical health.

Psychological health was measured using a list of stress symptoms and assessing contact with a counsellor (Rolph et al., 2011a). In assessing this domain, no consideration of positive mental supports were given. Religious health was examined by asking if the participants had spiritual needs, doubts, or time to meet their spiritual needs (Rolph et al., 2011a). More space was given to the spiritual health domain, exploring thoughts across the personal, communal, environmental, and transcendental facets (Rolph et al., 2011a). The conclusions from this study, considering the previous limitations, overstate findings. The study ascertains this group have poor levels of health across the investigated domains, also stating that clergy are under significant levels of pressure with inadequate support structures (Rolph et al., 2011a). It is questionable whether these conclusions can be drawn from the data provided in this publication. Despite the significant study limitations, it is one of few UK studies that attempts to consider a more holistic view of clergy health. Unfortunately, the study did not consider holism as per common medical models, or how to adequately gauge optimal / sub-optimal health across the domains investigated.

2.4.6 Clergy Role Conflict

In an early study, Francis et al. (2008) considered work satisfaction and churchmanship in 1071 Church of England clergy. The study considered the varying roles of clergy, identifying five distinct separate roles: “Religious Instruction, Administration, Statutory Duties (conducting marriages and funerals), Pastoral Care, and Role Extension (including extra-parochial activities)” (Francis et al., 2008, p.

327). This definition parallels with other works, however, perhaps presents a myopic view of the range of role demands, particularly in 'role extension'. A piece in the Elim Pentecostal church, for example, examining job satisfaction, identified 20 different roles: "administrator, apostle, counsellor, evangelist, fellowship-builder, fund-raiser, leader in local community, leader of public worship, man or woman of prayer, manager, minister of sacraments, pastor, pioneer, preacher, prophet, social worker, spiritual director, teacher, theologian and visitor" (Kay, 2000a, p. 91). Additionally, UK mental health research group Leavey et al. (2007; 2008; 2012; 2016; 2017) has published several works regarding the place of clergy and faith-based organisations as community supports and sign-posters in local level mental health care. Despite any differences in methodologies or focus in these pieces, it is evident that trans-denominational clergy roles are diverse. It is in this diversity where potential occupational health issues may arise, e.g., boundary setting, poor work life balance, effort-reward or job demands-resources imbalance.

Role definition appears an important factor to clergy occupational health, indeed findings show both role ambiguity and role conflict perpetuate lower levels of role satisfaction in the clergy cohorts examined (Faucett et al., 2013; Kemery, 2006). One US Methodist study indicated a cumulative effect, with the high presence of both role ambiguity and role conflict leading to low occupational satisfaction (Kemery, 2006). However, a level of ambiguity (and low role conflict) has been shown to promote role satisfaction, potentially allowing space for role moulding and personalisation (Kemery, 2006). This may provide a potential rationale for the initial success of the Diocese of Sheffield (n.d.; 2014) project. Yet, a further US Methodist study showed no significant relationship when ambiguity was low, with role satisfaction and conflict (Faucett et al., 2013, p. 298). However, "…when role

ambiguity was high, there was a significant negative relationship between role conflict and intrinsic job satisfaction" (Faucett et al., 2013, p. 298). Irrespective of the cumulative or linear impacts, it is evident that role conflict and ambiguity may have a complex impact on clergy. Although the demands of the role cannot always be adjusted, in the context of this thesis it would be advantageous to begin to explore if UK Baptist clergy share similar role demands, in particular, how this may create barriers or facilitators to self-care.

2.4.7 Francis et al. Conclusion

Francis et al.'s (2008; 2011b; 2013; 2017a; 2017b; Francis & Robbins, 2002; Rolph et al., 2011a) work does not robustly explore health and wellbeing in the holistic sense, despite being one of the few groups to investigate UK clergy health. Although some works consider Baptist clergy, the authors group Baptists with general Free Church and other evangelical denominations, some with quite different organisational and operational structures (Francis et al., 2011b; Francis & Robbins, 2002). This approach misses the opportunity for valuable Baptist data collection, comparison with other denominations, and highlighting significant differences.

Some useful conclusions may be drawn from the use of tools such as the FBI and incorporating the balanced affect model, however, it does not appear, from the published works, that Francis et al. (2013; 2017b; 2019) have translated their works into real-world impactful recommendations for the cohorts under investigation. An argument is presented, through the use of the FBI and the FPTS, for stress symptoms, low levels of psychological wellbeing, person-role miss-fit, and dissatisfaction within the Anglican communion in the samples investigated (Francis et al., 2008; 2017b; Francis & Rodger, 1994; Rolph et al., 2014).

2.5 Other UK Publications

A scant selection of other UK works across several denominations have been published and identified in this literature search.

2.5.1 Rolph and Rolph (2008) – High Job Demands, Stress Symptoms

Rolph and Rolph (2008) conducted a small qualitative study in rural clergy with similar results to Francis' work. The study suggested high job demands and stress symptoms in the cohort. It did, however, place an onus for stress management on the individual *and* the wider church, concluding the study with a call for more research into clergy stress and wellbeing (Rolph & Rolph, 2008). Despite being an older article with only 11 participants, this piece adds to the small body of work in the UK to present an argument for further investigation.

2.5.2 Kay (2000a; 2000b) – Pentecostal Studies

Kay (2000a) produced a large UK Pentecostal male clergy study, with 699 respondents, exploring ministerial job satisfaction. This study examines several Pentecostal sub-denominations e.g., Elim, Assemblies of God etc. grouped together under the Pentecostal umbrella. The study does state, however, that these groups have 'broad similarities' between their operational structures, yet differing governmental structures (Kay, 2000a, p. 90). As denomination specific governing bodies often oversee factors such as counselling, finance, and mentorship opportunities etc. it could be suggested, to obtain a fuller picture of ministerial job satisfaction, sub-denomination break down in this larger study would have been advantageous.

The study explored ministerial roles and satisfaction, asking clergy to rate 20 identified roles on a seven-point Likert scale: “How much personal satisfaction they felt they derived from each role” (Kay, 2000a, p. 91). Notably within this group, role specific factors, evangelism, control, charismatic ministry factors and holiness, all showed statistically significant results to the $p<.01$ and $p<.001$ level in relation to ministerial satisfaction (Kay, 2000a). Yet, age, thoughts of leaving ministry and salary did not show a statistically significant impact on satisfaction (Kay, 2000a). These results are notable in the context of Watt and Voass’ (2015) Church of England work, which found age to show significant differences in older and younger clergy in terms of innovation, persistence, and envisioning skills. Despite the 15-year gap in the studies, this indicates some potential differences trans-denominationally, and further highlights the necessity for a specific denominational breakdown of results.

The study concludes with the statement: “As they stand, however, they should give encouragement to ministers and those involved in their training, since they demonstrate that the motivation of ministers is not primarily fixed on earthly rewards or comforts” (Kay, 2000a, p. 95). This is a challenging conclusion, as it could be potentially misconstrued that salary or other supports are irrelevant to the minister’s ability to conduct their role, or in role satisfaction generally. Yet, when holistic health and wellbeing are considered, particularly the interrelationship between facets, such as financial and psychological health, it is known that one area can significantly impact another. This piece is a further example of necessity for balance when reporting results. Statements such as that cited above, have the potential to negatively impact the direction and focus of support strategies and interventions of governing bodies and training institutions.

This same data set was used in a subsequent publication where all 930 questionnaires were used to explore subjective role conflict across the 20 identified clergy roles (Kay, 2000b). This exploration used the dissonance between questions "How much priority do you *want* to give to the following aspects of ministry?" (Kay, 2000b, p. 121) and how much are you expected to give. Notably, 18 of the roles indicated subjective statistically significant role conflicts, with clergy rating their subjective external expectations across the 18 domains as significantly higher than their personal perceptions of role priority (Kay, 2000b). Factors "fellowship builder and leader in local community" showed no statistically significant difference (Kay, 2000b, p. 121). These results indicate potentially high external and personal perceived expectations regarding their place in local communities. These perceptions further highlight the importance of self-care for role maintenance and as a potential community example.

2.5.3 Kinman et al. (2011) – Social Support

Kinman et al. (2011) undertook a study assessing emotional labour and the impact of job roles on the personal wellbeing of 188 UK clergy. This study does not state which denominations were under investigation. As previously stated, job demands and support do differ trans-denominationally, ergo in this investigation it may have been advantageous to differentiate. This study, in part, focused on relational aspects of the profession that may mitigate emotional labour, highlighting the role of social support in promoting emotional wellbeing and job satisfaction (Kinman et al., 2011). Most notably, it suggested that not all social support is created equal, in that some forms, such as community or professional networks, may be demanding and provide further emotional strain for the minister (Kinman et al.,

2011). This work highlights the importance of person fit to the support strategy. The work also contrasts with the findings of Francis et al. (2013) where the simple 'provision' of a mentor and / or peer group were suggested as stress reduction tools, yet 'fit' was not examined. In the context of this thesis therefore, barriers and facilitators to self-care activities in the social domain will be examined.

2.5.4 Guthrie and Stickley (2008) - Spiritual and Mental Distress Perceptions

A small Nottinghamshire study with six participants investigated clergy's perceptions of spirituality and mental illness or mental distress (Guthrie & Stickley, 2008). Within this study the inclusion criteria for 'clergy' was informal. Four participants belonged to the Church of England, two of which were chaplains, not working as formal church leaders. The fifth participant was a Salvation Army officer, and the sixth a Christian counsellor said to be '…representing a non-denominational community church" (Guthrie & Stickley, 2008, p. 392). This broad inclusion criteria explores the range of contemporary clergy postings where leaders may be officially trained and / or ordained, or may be bi-vocational e.g., a health practitioner and a leader. Additionally, some clergy may have originally been in traditional church leadership, but then moved to alternative communities such as a hospital, college, prison, or served as regional chaplains (Baptists Together, n.d.-a; n.d.-b; 2016; Samushonga, 2019). Although the sample in this study is small, the work clearly states the sample is not representative of the wider population, but does provide a basis from which to frame other clergy spirituality and mental wellbeing studies (Guthrie & Stickley, 2008) remaining a valuable contribution to the limited research field.

Notably, the study used a traditional method of generating themes post-transcription, forgoing contemporary programs e.g., NVIVO, in favour of hard copy colour coding with pens (Guthrie & Stickley, 2008).

Despite not being a direct clergy health and wellbeing study, this work was useful in exploring clergy's understanding of mental health, mental distress, and their causes. This topic in the theological sense has been historically challenging in some denominations. Some archaic views consider all mental health issues and mental distress as solely works of demonic forces, or indeed some discount the modern possibility of hearing directly from God in prophecies, visions, and dreams. Authors linked to Durham University Centre for Spirituality, Theology & Health, however, have produced several articles on perceptions of mental illness, religious coping, and hearing from God (e.g., hearing voices) (Cook, 2020; Dein & Cook, 2015; Dein et al., 2010; Woods et al., 2014). These factors are important foundational considerations when exploring the mental health facet in Baptist clergy, namely how they may perceive and respond to their personal mental wellbeing. The Nottinghamshire study does point toward some churches having a damaging imbalance in their approach to mental health or ill-health:

> There was, however, a clear recognition of the damage caused by the church to people experiencing mental-health difficulties resulting from a ‘‘very black and white view of spirituality’’ (B), which resulted in them putting a greater emphasis on the spiritual influences in mental-health problems (Guthrie & Stickley, 2008, p. 396).

The Nottinghamshire study, in essence, considers participants' perceptions of what is understood as the mental health continuum (MHFA England, 2016, p. 43) a fluid notion of mental health, where all humans reside on a spectrum influenced by

events and actions both supportive and detrimental (MHFA England, 2016). Some participants appear to have a basic understanding of the fluidity of mental illness: “I think there is a very thin line between the two, you know, and crossing from one side to the other I’m not sure where that takes place” (Guthrie & Stickley, 2008, p. 393). Whereas others appear to struggle with the concept of recovery: “I would call mental distress any sort of upset, but when you get to mental illness it is more of an um. . . permanent nature than a temporary nature” (Guthrie & Stickley, 2008, p. 393). This misunderstanding of the permanence of mental illness is contrary to the approach of contemporary institutions such as MHFA England, which promote the understanding that recovery is possible, but said recovery looks different for different people (MHFA England, 2016, p. 39). Ergo, some in this cohort (and potentially other clergy cohorts) may adhere to this notion, creating further personal mental distress in times of crisis. All participants stated: “…everyone experiences mental distress at some point in their lives. This was said to be a normal emotion and expected reaction to general life experiences” (Guthrie & Stickley, 2008, p. 393). This, therefore, raises questions, if clergy expect some level of mental distress as a normal reaction to general life events, how do clergy personally respond in these situations, and most importantly, what do they engage with to bolster their mental wellbeing? This thesis will aim to explore the barriers and facilitators to self-care in several domains, including mental health and wellbeing.

Finally, this study begins to explore the interrelatedness and holistic nature of health, namely between spiritual and mental distress, the study suggesting participants support the interlinked nature of health (Guthrie & Stickley, 2008, p. 395). Overall, examining clergy’s understanding of holism, mental health and illness are useful considerations in the design of this thesis’ investigations.

2.5.5 Berry et al. (2012) - Welsh Clergy Stress Review

Berry et al. (2012) conducted a study investigating work-related stress symptoms in 73 Welsh Anglican clergy. Seeking a broad profile, their work explored areas including personal health, stress symptoms, support, and relaxation (Berry et al., 2012). Participants were asked to self-rate their health and provide descriptors of stress symptoms, stress characteristics, causes, and sources of support etc. Participants identified a range of mainly psychological stress symptoms, indicating a limited understanding of the broad impact of stress (Berry et al., 2012). However, when asked about their own experiences, four out of five participants stated they had experienced physical symptoms of stress, including fatigue and sleep disturbances, they felt, as a direct result of stress (Berry et al., 2012). The causes of the experienced stress were most cited as volume of work (including meetings) conflicts and challenging people, administration, unrealistic expectations from others, and lack of support and understanding from congregants (Berry et al., 2012). These findings mirror the works of Graveling (2018b) and Wyatt et al. (2017; 2019) and the publications of Kay (2000b) and Rolph and Rolph (2008) building an overall picture and an argument for commonly felt stress symptoms in the profession.

The second part of the study focussed on sources of support for stress, the most cited sources were personal relationships (friends, family, partners etc.) (Berry et al., 2012). When asked their thoughts regarding professional pastoral support, clergy were divided, some felt there were suitable options available, where others felt the issue was not with the options per se but with access and reluctance (Berry et al., 2012). These responses correlate with the findings of Kinman et al.'s (2011) investigation, who suggested that not all social support was created equal, and person fit was an important factor in suitability. When considering support and accessing it,

this study did highlight that some clergy viewed support seeking as being a sign of weakness or spiritual failure (Berry et al., 2012). This indicates a disconnect between their broad understanding of stress and their perceptions of who may experience stress.

Berry et al. (2012) found that 55 of the 73 participants felt their initial training was insufficient to prepare them for the stresses of ministry. When clergy were asked what elements may improve this training, responses focussed heavily on placements, early practical parish involvement, and scenario practice (Berry et al., 2012). Some did suggest stress management training or courses, but despite clergy citing forms of 'relaxation' in an earlier question, no participants cited these methods as suitable means of stress management in the professional sense. Again, this indicates lower levels of knowledge regarding the range of suitable self-care (stress management) strategies in the primary, secondary, and tertiary sense.

2.5.6 UK Research Conclusion

The UK works appear to be dominated by Francis et al., and the Anglican communion. There is little representation of other UK denominations, and where they do feature, differing denominations are often grouped together, offering a limited profile.

Although in the cohorts investigated, some clergy report finding meaning and satisfaction in their vocations (Kay, 2000a; Kinman et al., 2011) some studies indicate a high number of job sub-roles within the clergy profession (Francis et al., 2008; Kay, 2000a). Additionally, studies observed high job demands, role expectation / personal perception conflict, stress symptoms, and some potential differences in support strategies and focus across denominations (Berry et al., 2012;

Guthrie & Stickley, 2008; Kay, 2000b; Kinman et al., 2011; Rolph & Rolph, 2008). Some works highlight a potential disconnect between health understanding, current actions, support provision and person fit (Berry et al., 2012; Kinman et al., 2011).

Despite two studies featuring some Baptist clergy (Francis et al., 2001b; Francis & Robbins, 2002) there are no comprehensive UK Baptist holistic health or self-care investigations to date. Despite this thesis' focus on works pertaining to Baptist clergy, there appears, to date, a UK research neglect in other trinitarian Protestant denominations which should be a consideration for future researchers.

The methodology and claims of some studies are challenging. This supports the need for thorough, clear, accurate, and contemplative study outputs, either in publication or denomination specific recommendations (Francis et al., 2013; Kay, 2000a; Kinman et al., 2011).

Overall, the available UK published works present an argument for personal and professional self-care challenges felt by some clergy in select denominations. The available UK evidence, to date, demonstrates a clear research gap in Baptist clergy occupational health research supporting the unique contribution of this thesis.

2.6 International Research - USA

This literature review identified a clear gap in UK clergy research, indeed, US researchers Proeschold-Bell and McDevitt (2012) suggest a significant deficit in international clergy works generally. As such, the wider international research was considered, however, the potential cohort differences are noted particularly where culture and lifestyle may differ significantly. The following, therefore, provides a succinct overview of some of the key international studies.

2.6.1 Duke Clergy Health Initiative

The main body of international works focus on the United Methodist Church (UMC) the second largest formal Protestant denomination in the US (US Religion Census, 2020). The aim of these works, produced by Proeschold-Bell et al. in the Duke Clergy Health Initiative, was to profile and improve the health and wellbeing of UMC clergy serving in North Carolina (Duke Divinity School, n.d.-a; n.d.-b). The three-stage project appears, to date, to be the most comprehensive, holistic, theoretically founded, and real-world effectual clergy health investigation and intervention (Duke Divinity School, n.d.-b).

2.6.1.1 Part One – UMC Health Profiling (Qualitative Stage).

Part of this sizable $12 million project sought to develop a theoretical model of clergy health using 11 focus groups with 88 clergy and district superintendents (Proeschold-Bell et al., 2011; Proeschold-Bell & Byassee, 2018; Webb, n.d.). The team used the socioecological framework within this study to consider five factors that may influence health: “Intrapersonal, Interpersonal, Congregational, United Methodist Institutional, and Civic Community” (Proeschold-Bell et al., 2011, p. 700). Socioecological theory, developed by Broffenbrenner in the 1970s, seeks to examine health holistically, namely the influence and interrelationship between the intrapersonal facets and wider environmental and social factors (Kilanowski, 2017). This is an important consideration in the context of clergy who are guided by larger country wide organisations such as the BUGB, where social and institutional norms may impact behavioural choices and sustainability.

This primary stage’s outputs most notably support the relationship between the health facets positing that a singular self-care strategy may affect several areas of

health (e.g., exercise promoting both mental and physical health) (Proeschold-Bell et al., 2011). The team firmly state their holistic research approach: “In this model, we define our final health outcome holistically in order to indicate that health is not merely the absence of problems but is, rather, the presence of multiple life satisfactions” (Proeschold-Bell et al., 2011, p. 705). Further stating: “Ultimately, we believe the data suggest that physical and mental health and spiritual well-being are inextricably intertwined…” (Proeschold-Bell et al., 2011, p. 712).

The team found 42 factors that may impact clergy health, those found to have the greatest impact were “…ability to set boundaries, perception that the pastor is available 24 hours/day, church health and functioning, itinerancy, and financial strain (Proeschold-Bell et al., 2011, p. 705). The first factors are notable in the context of UK Baptist clergy where they are called to be available, and where the expectation of ministry is a “way of life” (Baptists Together, 2011, p. 3).

Proeschold-Bell et al. (2011) also found congregational support of clergy self-care a significant motivator for action. Several authors have too identified social support and ‘intrapersonal’ factors that play a significant role in upholding the minister, such as social support, acting as a job resource and, in some cases, being a predictor of burnout (Evers & Tomic, 2003; McMinn et al., 2005, p. 574; Rothmann & Buys, 2011; Tomic et al., 2004). McMinn et al. (2005) however, highlight the frequent lack of engagement clergy have with social circles, and the difficulties clergy may have in making and sustaining social relationships outside their immediate family (McMinn et al., 2005). The concept of congregation (and other external) support is a useful factor to consider, and one that will be explored in this thesis works.

2.6.1.2 Part Two – UMC Health Profiling (Quantitative Stage).

The second stage invited all UMC clergy in North Carolina to participate in a self-report health survey, this had a remarkable 95% response rate (Proeschold-Bell & Byassee, 2018). The findings from the 1,726 clergy participants were compared with the general adult population showing:

- Clergy experience depression at a rate 2.89% higher than the national average (Proeschold-Bell et al., 2013b).
- BMI (body mass index) in those aged 35-64 was 10.3% higher than comparative adult populations (Proeschold-Bell & LeGrand, 2010).
- Alongside 39.7% of participants being in the obese range, clergy also reported higher instances of "…diabetes, arthritis, high blood pressure, angina, and asthma compared to their NC peers" (Proeschold-Bell & LeGrand, 2010, p. 1867).

Despite this body of work focussing on the state of North Carolina, unpublished works with a wider reach in the UMC paint a similar picture. WesPath Benefits / Investments' (2017; 2019; 2021b) a not-for-profit financial support agency serving the UMC, 2019 figures of 1,200 clergy show:

- 81% were in the overweight / obese category (78% in the 2012 report).
- 8% experience clinical depression (7% in 2017) and 29% feel down or experience feelings of hopelessness.

The national UMC health disparities identified in these studies support the necessity to profile UK denominations. Data is needed to consider if UK clergy share

similar health concerns to their US counterparts, alongside the specific barriers and facilitators to health and wellbeing self-care.

2.6.1.3 Part Three - ‘Spirited Life’ Intervention.

Based on the findings from the previous two phases, the team delivered a tailored health improvement intervention in three staggered intakes between 2011 and 2016 with 1,114 UMC clergy (Proeschold-Bell & Byassee, 2018; Proeschold-Bell et al., 2017). Notably, the delayed participation dates were shown to be positive with some participants, allowing space to strategize time and resources to fully engage in the project (Proeschold-Bell & Byassee, 2018). The project sought to positively impact stress symptoms, depression, and symptoms of metabolic syndrome through a structured multidisciplinary program (Proeschold-Bell et al., 2013a; 2017).

Data showed statistically significant reductions at the two-year time points in central obesity, hypercholesterolaemia and hypertension, with all cohorts showing decreased incidence of metabolic syndrome, however no statistically significant findings were shown for stress or depression (Proeschold-Bell et al., 2017). Data analysis did, however, indicate the protective effect of spiritual health as a preventative measure for depressive symptoms and occupational distress, further evidencing holistic health interlinking (Milstein et al., 2020).

In their book Proeschold-Bell and Byassee (2018) cite lessons learned, and specific successful factors arising from the intervention. Recommendations included working holistically, participant led content, discussing mental health in such a way that reduces stigma, and incorporating methods that promote ‘permission’ to self-care (Proeschold-Bell & Byassee, 2018). Given the project’s success, considering these factors in the current thesis’ investigations may be useful.

2.6.2 Other US Works - Denominational Support of Self-care Strategies

Independent large scale clergy research has been conducted by the Schaeffer institute into clergy wellbeing since the late 1980s. The latest data conducted 2015-2016 research employed mixed methods, to explore the health and wellbeing of 8,150 evangelic and reformed clergy (Krejcir, 2016, para. 7). Of those surveyed, 90% felt honoured to be a pastor, yet, 54% worked over 55 hours per week (18% working over 70 hours) 26% expressed feelings of significant fatigue, 35% were depressed, 12% felt belittled, and 9% were classified as burnt-out. These results correlate with Clinton et al.'s (2017) UK work, where results suggested that intense calling may lead to long work hours, poor sleep quality and knock-on fatigue. Cultural sensitivity must be given to the powerful and often spiritual sense of calling, however, as indicated from the US and UK research, results point towards the necessity for supportive interventions in these denominations.

Trihub et al. (2010) investigated the effects of support strategies including retreats, prayer and spiritual support, and time off etc. (Trihub et al., 2010). However, the study identified significant barriers to clergy engagement including cost or personal finances, time off to engage, as well as some clergy raising concerns regarding confidentiality and general lack of awareness of available services (Trihub et al., 2010). Bopp et al. (2013) also consider the wider influences on clergy health outcomes arising from organisational structures. They suggest the importance of balancing health interventions with current clergy demands (i.e., suitable time resources to engage) alongside implementing multi-level longitudinal approaches to tackle organisational concerns wider than the individual minister (Bopp et al., 2013). These findings suggest clergy must be educated as to what support strategies are available, *and* be able to freely (and confidentially) engage as required. The onus

being on the individual *and* the organisation, tackling clergy health, like Proeschold-Bell et al. (2011) through a wider lens (e.g., the socioecological model of health).

2.6.3 Dissertations and Theses

In addition to the published works, several dissertations and theses are available, primarily from the US and North America, which provide further evidence of lower levels of clergy holistic health, and the necessity for interventions. A significant volume of these works focuses on clergy in the Southern Baptist Convention, with others examining the Church of the Nazarene and the Anglican communion. The investigations use a variety of methodologies and a wide range of participant numbers. Despite the differences in approaches and denominations, these works largely mirror the previous UK and international findings:

- Clergy have an awareness of the necessity for care of the body, acknowledge holism, and the interrelationship between care of the spiritual self and care of the body (Cowper, 2012; Jenkins, 2018).
- Clergy cite the biblical imperative to care for their physical health, and that they can honour God with their bodies (Cowper, 2012; Elders, 2010).
- Clergy need to intentionally engage in self-care practices (e.g., journaling, prayer, bible study etc.) to support their health and wellbeing (Cowper, 2012; Jenkins, 2018; Larson, 2020). The degree of engagement in these coping resources, being a statistically significant predictor of exhaustion (Moore 2010).
- Clergy experience complex social relationships particularly with congregants, and boundary setting is necessary (Jenkins, 2018; Larson, 2020).

- There appears a disconnect between health knowledge / behaviours, and self-rated health. For example, in Elders (2010) survey, many clergy reported a fitness level of >five (on a 10-point scale) having previously cited engaging in zero-one exercise episodes per week.
- Some clergy self-report being overweight (Elders, 2010).
- Some clergy are at significant risk of burnout, and consider leaving the vocation (Hollins, 2018; Rowell, 2010). In Rowell's (2010, p. 71) Nazarene investigation, the top two most cited reasons for leaving or considering leaving, were fatigue and conflict with congregants.
- Some clergy experience poor person fit with support personnel (e.g., denominational hierarchy, mentors, and training incumbents) (Marlow, 2017; Rowell, 2010).
- Some clergy experience major depressive symptoms at a significantly higher rate than comparative populations (Proulx, 2008, p. ii).

Due to limitations in sample size, limited denominations, and restricted focus on select health facets and outcomes in the available published works, these student works further strengthen the argument for more clergy health research, particularly in the UK.

2.6.4 The Web of US Works

The denominations investigated have varied, with some focussed solely on the UMC, where others investigated a specific occupational concern such as burnout across several denominations (e.g., Beebe [2007]). Where Baptist clergy were mentioned, they were grouped with other denominations with no obvious differentiation (Beebe, 2007; Darling et al., 2004; Holaday et al., 2001; Moore et al.,

2017; Rowatt, 2001; Weaver et al., 2002). Proeschold-Bell et al. in their works (2010; 2011; 2012; 2013a; 2013b; 2017) have cited many of these clergy studies to underpin their large scale UMC study. Cumulatively, these US findings point to similar health concerns to those identified in the UK literature. These additional findings indicate US Clergy (in the cohorts investigated) present or are faced with:

- Burnout (Chandler, 2009; Darling et al., 2004; Doolittle, 2007).
- Challenges with poor work life balance and high job demands (Chandler, 2009; Hill et al., 2003; Meek et al., 2003; Rowatt, 2001; Weaver et al., 2002).
- Damaging occupational criticism (Hill et al., 2003; Weaver et al., 2002).
- Depression (CREDO Institute, 2006; Doolittle, 2007; Holaday et al., 2001).
- Distress (Weaver et al., 2002).
- Emotional exhaustion (Doolittle, 2007; Holaday et al., 2001).
- Fatigue (Chandler, 2009).
- Obesity and / or unhealthy eating behaviours (ELCA, 2002; Harmon, 2013; Lindholm et al., 2016; Moore et al., 2017).
- Social health challenges (Hill et al., 2003; Meek et al., 2003; Rowatt, 2001; Staley et al., 2013; Weaver et al., 2002).
- Spiritual health challenges (Chandler, 2009; Rowatt, 2001).
- Stress symptoms (CREDO Institute, 2006; Doehring, 2013; Hill et al., 2003; Holaday et al., 2001; Rowatt, 2001; Weaver et al., 2002).

2.7 Australia – The Australian National Church Life Survey

The most prominent remaining work is The Australian National Church Life Survey. This survey has been conducted in intervals since 1991, exploring congregational, operational, and leader life. One of the largest quantitative studies in Australia, it reports the findings of 6,625 pastors, church counsellors, and elders across 23 denominations (Pepper et al., 2015). Findings from this study show significant similarities to other international works e.g., data indicate that religiosity and spiritual resources, were positively associated with work engagement and personal wellbeing (Dowson & Miner, 2015; Miner et al., 2015). Again, where Baptists did feature in reports, denominations were grouped and individual denominational differences were not discussed (Pepper et al., 2015).

Two examinations of the data set suggested higher work-related psychological health, and lower levels of burnout in extroverts, suggesting that personality type plays a statistically significant role as a predictor of burnout (Robbins et al., 2012; Robbins & Hancock, 2015). As with the previous UK studies however, this assertion may be somewhat limited when considering the clergy vocation. Clergy, as seen from the previously discussed literature, having complex personal and occupational health which is shown to be impacted by external factors such as support. Indeed Miner et al. (2015) notably reported on the complexities of clergy wellbeing. Although personality type may influence resilience and help seeking behaviour etc., to obtain a broad, robust picture of clergy health, other variables should be considered.

2.8 2024 Update

During the execution of this thesis' investigations, other research and intervention efforts have taken place which continue to highlight the health and wellbeing challenges clergy experience. These data point to similar holistic health concerns as this thesis' results. Overall, these data suggest a need for more UK trans-denominational research and interventions.

2.8.1 UK Multidenominational Works.

Contemporaries of Francis conducted a psychological type investigation within the BUGB (Garland & Village, 2022). They concluded that within their sample there were distinct differences in the psychological types of Baptist and Anglican clergy (Garland & Village, 2022) this is supportive of the necessity to conduct denomination specific research, as in this thesis. Most notably, their findings point toward strong core values, and an openness to well-planned strategic changes (Garland & Village, 2022). Ergo, if changes such as self-care practices are supported and well structured, they may be well received by Baptist clergy, further supporting the intervention approach in this thesis.

Edwards et al. (2022; 2023) explored psychological factors in a variety of UK clergy, including a small number of Baptists. Their recent works highlighted that, despite religious coping, clergy cited a need for change within the church culture to better support them in their ministerial challenges (Edwards et al., 2022). The work explored some of the feelings of clergy and the resigned sacrifice that comes with the vocation: "And Jesus got crucified, so why should we expect anything any different?" (Edwards et al., 2022, p. 466). Notably, this thinking aligns with some of the findings of Study two where one participant stated: "…now and

then one has to have one's Gethsemane and get on with stuff, but it shouldn't be all the time" (B4). Additionally, clergy cited similar psychological strain to the findings of this thesis, reporting symptoms of exhaustion, depression, anxiety, and high job demands (Edwards et al., 2023). Most notably their work suggests that clergy report favouring support from informal sources (e.g., partners, friends, and other clergy) over professionals, with about 10% of their sample not seeking any support. These findings align with the peer support facilitators highlighted in Study two, and the design of Study four. This further affirms the suitability of the Padlet peer support section, and the general necessity for further clergy health interventions.

2.8.2 General Biopsychosocial Landscape and Risk to Clergy Health

A national government backed report by Mental Health UK (2024) surveyed working age UK adults in relation to burnout symptoms, risk, and support. The survey stated that since the COVID-19 restrictions, one fifth of UK workers have taken a leave of absence due to stress, 91% stated they were facing high or extreme stress, and 49% stated their employer does not have a plan in place to recognise and prevent stress and burnout (Mental Health UK, 2024, pp. 9-10). Most notably, those surveyed stated poor sleep, the cost-of-living crisis, physical health issues, and feeling isolated were significant contributors to their stress (Mental Health UK, 2024, p. 9). Additionally, those factors which helped respondents alleviate their stress were reported as strong support networks outside of work, healthy work life balance, exercise, a supportive line manager, mental health support, work adjustments where necessary, and training around mental health at work (Mental Health UK, 2024, p. 11). Sport England (2024) however, reported that 63% of adults

have reduced disposable income, and 36% reported that the cost-of-living crisis was affecting their ability to engage in exercise.

As shown in the OLBI figures in Study one, some Baptist clergy too appear to be experiencing similar burnout symptoms. However, the helpful support strategies suggested in the Mental Health UK (2024) report (e.g., strong support networks) appear to be significant areas of challenge for clergy. For those healthy clergy, it is highly likely given these figures, that they will have team members, clergy colleagues, and congregants experiencing high levels of stress and burnout, adding to their workload. These national stress and burnout figures, in conjunction with this thesis' findings, provide a robust justification for contemporary strategic interventions, training, and support approaches.

Although the UK no longer faces COVID-19 restrictions, it is clear, as previously discussed, that lasting health issues remain, in addition to other national and global socio-political issues. Church of England researcher Graveling (2000, p. 7) states "It is important to take a wide perspective and not draw hard lines between ministry and other aspects of life". Given the ministry landscape, possible increased occupational pressures, and the findings of this thesis, actively adopting strategies to promote holistic self-care in Baptist clergy (akin to the Church of England covenant [Butler, 2019]) appears logical.

2.8.3 US

In the US, internal figures and published works continue to demonstrate lower levels of holistic health and wellbeing against comparative populations.

WesPath Benefits / Investments (2017; 2021a; 2023) demonstrate a pattern of UMC clergy health and wellbeing decline in their latest 2023 figures:

- 49% were obese (6% increase from 2017)
- 14% have diabetes (2% increase from 2017)
- 10% were experiencing depression (3% increase from 2017)
- 52% were experiencing work related stress (7% increase from 2017)
- 33% felt lonely and isolated in their work (3% increase from 2017)
- 28% reported not feeling understood by family and friends (6% increase from 2017)

Shaw et al. (2021) surveyed 93 clergy from a variety of unspecified US Christian denominations, their results show similar findings to that of the UMC. In their study, 50% reported mild, moderate, or moderately severe depression symptoms. In comparing their population means to a clergy sample from 2013, they found statistically significant experiential levels of demand, criticism, stress from criticism, loneliness, and stress from challenges (Shaw et al., 2021).

Other researchers have observed similar recent clergy holistic health concerns:

- Depression (Upenieks & Eagle, 2024)
- Stress, vicarious trauma (Sielaff et al., 2021)
- Lack of congregational support and need for congregational education to support clergy (Sielaff et al., 2021; Upenieks & Eagle, 2024)
- Complex spiritual health needs (Terry & Cunningham, 2021; Upenieks & Eagle, 2024)
- High job demands (Terry & Cunningham, 2021)

Notably, Case et al. (2020) conducted interviews with UMC clergy, linked to the Spirited Life intervention, to identify what facilitates positive mental wellbeing. Their results show that those clergy with positive mental wellbeing took an intentional approach to their personal health, as well as being aligned with God's plan for their lives and setting clear boundaries (Case et al., 2020). Additionally, Sielaff et al. (2021) in their review, found that clergy who intentionally practice self-awareness, e.g., in support groups and reflection, had increased resilience. Furthermore, Yao et al. (2023) found that those clergy who use theologically based messages to prompt behaviour change have greater success and sustainable changes in dietary choices, physical activity, and sleep quality. Most notably these approaches align with this thesis' intervention, where reflection, peer support, theological messages, and personal goal setting were central.

In lieu of UK Baptist data, these data provide useful reference points, despite the differing denominations, cultural and occupational demands. It appears, like the participants in this thesis, that some clergy in these US investigations are experiencing poor wellbeing, with few supportive interventions. Terry and Cunningham (2021) in their trans-denominational investigation of 332 clergy, stated that half of their respondents agreed that their work has a negative effect on their health. Secondary and tertiary interventions have their place, however, as stated by Case et al. (2020) more work should be focussed on primary prevention. Additionally, Sielaff et al. (2021) highlight that supporting clergy resilience development is multifaceted and requires input from support agencies, congregations, leadership teams, and individual clergy. As feasibility and acceptability were shown in this thesis' intervention, these collective data provide a

further rationale for future interventions, research, and multilevel targeted strategies to support UK Baptist clergy holistic self-care.

2.8.4 Canada

Recent multidenominational clergy resilience research shows distinct similarities in facilitators to personal wellbeing to that of the generated themes in this thesis' works including:

- Spiritual support, calling, and personal relationship with God
- Spiritual practices including retreats, solitude, daily offices, spiritual writings, prayer, and sermon preparation
- Balance, holism, and rhythms
- Select social supports including, family, friends both inside and outside the church, spiritual directors, mentors, counsellors, support agencies, and peer relationships (Clarke et al., 2022).

Clarke et al. (2022, p. 217) also highlighted the distinct benefits from peer learning approaches in clergy stating, 'equals' can offer "…support … wisdom and openness resulting in learning from each other". These findings, unlike the previous US works, begin to uncover the possible approaches that may be taken to support clergy self-care. When taken together, despite population differences, this study, and this thesis works break ground on possible primary prevention approaches for an occupational group with clear complex health and wellbeing needs.

2.9 Chapter conclusion - Search Findings and Aims

The existing literature points towards several broad clergy holistic health and wellbeing issues. Significant gaps in UK research have also been identified.

2.9.1 What is Known

- Collectively the UK and international research presents an argument for holistic health concerns in clergy trans-denominationally across the mental, emotional, occupational, physical, spiritual, and social health domains.
- Clergy health and wellbeing is complex. Health is holistic and multifaceted. To comprehensively explore clergy health and wellbeing, examinations must be executed using a holistic lens.

In the denominations and cohorts investigated:

- Clergy can experience feelings of strong role calling. However, clergy in their callings are not immune to significant holistic health issues.
- Clergy roles are complex. Clergy undertake many sub-roles as part of their vocation. Due to role ambiguity, and ill-defined expectations, clergy, may experience high job demands and may be at risk of subsequent occupational health issues such as burnout.
- Clergy occupational health transcends the individual, being both an individual *and* organisational responsibility.
- Health is impacted by individual behaviours and wider influences (e.g., community, social norms, government agenda etc.). When considering occupational recommendations, the use of a framework, such as the socioecological model, may be beneficial.
- Clergy health and wellbeing support appears on the radar of some denominations. There appears however, some issues with clergy's ability to access or fully engage in said support due to resources (e.g., time or poor fit).

- Planned, tailored, longitudinal clergy health interventions (e.g., that of Spirited Life) (Proeschold-Bell & Byassee, 2018; Proeschold-Bell et al., 2017) appear to promote significant positive health behaviour change. This suggests some clergy are open and willing to change.
- There is a clear theological imperative to self-care. Researchers should be aware and sensitive to the place of theological, and religious practices, vocational calling, religious coping, spiritual experience, and manifestations (e.g., hearing from God).

2.9.2 What is Unknown

There is no UK occupational holistic health and wellbeing research, to date, in the Baptist denomination, as such, the following is unknown in the UK:

- The current state of Baptist clergy holistic health.
- The current self-care practices undertaken by Baptist clergy.
- Their perceived barriers and facilitators to holistic self-care.
- The barriers and facilitators to comprehensive congregant and church / organisational level clergy self-care support in the UK Baptist denomination.
- The effects of any tailored occupational holistic health promotion interventions. Therefore, additionally:
    - The styles and features of health promotion interventions which are deemed acceptable and are feasible for promoting behaviour change in this occupational group.

Chapter 3: Health and Wellbeing of Baptist Church Clergy: A Descriptive Study

3.1 Introduction

As discussed in Chapter two, UK and international research highlights health and wellbeing concerns among clergy trans-denominationally. Little is known about the health and wellbeing of UK clergy in general, however, and there is no research, to date, profiling the health and wellbeing of UK Baptist clergy. This represents an important knowledge gap as population health profiling is a necessary foundational step prior to any action or intervention to address health disparities. In response to this distinct knowledge gap, the current study aims to establish a profile of the holistic health and wellbeing of UK Baptist, clergy comparing findings to general adult population data and available Christian clergy data.

This chapter details the methodology used to obtain health and wellbeing data from a sample of UK Baptist clergy. Data were collected using an online questionnaire comprising validated quantitative measures of spiritual, mental, physical, social, financial, and occupational health. A description of the sample's health and wellbeing is presented in relation to meaningful comparator data. Following the presentation of results, the findings are considered within the wider research context, including the impacts of COVID-19 and restrictions. Despite the sample being smaller than desired, sufficient data were collected to facilitate comparison with international clergy and general population data, providing a preliminary descriptive health and wellbeing profile. Findings suggested that the health and wellbeing profile of this sample was broadly consistent with that of clergy internationally.

3.2 Research Questions

This exploratory study set out to address two research questions:

1. What is the holistic (spiritual, mental, physical, social, financial, and occupational) health and wellbeing profile of UK Baptist clergy?

2. How does the sample's health and wellbeing profile compare to the extant trans-denominational Christian clergy literature and general UK adult populations?

3.3 Method

This study involved administration of an online questionnaire to UK Baptist clergy (Appendix C). The sections below detail the method used.

3.3.1 Sampling

This study set out to secure the participation of a representative sample of UK Baptist clergy to make generalisations concerning health and wellbeing in this population. Public data are not available on the precise number of practicing Baptist clergy; however, it is estimated that approximately 1,400 Baptist clergy are accredited and practicing with the Baptist Union of Great Britain (Baptists Together, n.d.-b; T. Fergusson, personal communication, October 6, 2021). On this basis, with the confidence level set at the 5% level (alpha = .05) a minimum sample size of 302 cases was required to adequately power the analysis, according to the online sample size calculator (Calculator.net, n.d.).

An invitation to participate in this study was posted on Facebook, LinkedIn, and The Sheldon Hub (a trans-denominational clergy support website). The invitation was also directly messaged by the author to individual churches.

Additionally, the flyer was posted in closed networks (such as private collaboration and prayer networks) and sent to personal contacts within the Northern Baptist Association, Scottish Baptist College, and South Wales Baptist Association. Clergy friends and family also voluntarily reposted the advert and snowballed the invite within their own networks.

De Man et al. (2021, pp. 1-2) suggest five key considerations for online survey-based studies to maximise representativeness. These were adhered to as follows:

1) The presentation of balanced information to avoid attracting sub-groups.

This study was presented as a clergy health and wellbeing questionnaire. Participants were invited to share their health and wellbeing status as it relates to their ministry irrespective of current health, fitness, or disability status.

2) Using a broad selection of items to measure the participant characteristics.

Care was taken to obtain data on participant characteristics using items that collected rich individual data, whilst protecting anonymity.

3) Using multimodal advertising strategies, and the inclusion of a quick response (QR) code on flyers.

The invitation to participate was voluntarily distributed by supportive clergy to their colleagues. It was also emailed, posted on social media, featured on a prominent trans-denominational clergy support website, and included a QR code for ease of access.

4) Minimising questionnaire length.

During piloting, the questionnaire completion time was confirmed at approximately 20-minutes. Where available, short, validated measures were used in preference to longer versions. For instance, the 7-item Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS [Stewart-Brown et al., 2009]) was used in preference to the original 14-item version.

5) Disseminating results to participants.

The participant information sheet indicated that results of the study would be disseminated on request to those who participated using clear language void of jargon.

3.3.2 Questionnaire Piloting

Prior to questionnaire administration, a pilot was run with five volunteers. The purpose of the piloting exercise was to ensure that the instructions and questionnaire items were understood, that all links worked across devices, and that the questionnaire took no longer than 20-minutes to complete. From this pilot, minor adjustments for clarity and clergy specificity were made.

3.3.3 Questionnaire Administration

Ethical approval for the study was granted in late 2019 and the questionnaire went live on 31st January 2020. The original intention was to make the questionnaire available for six months to maximise the likelihood of securing a representative sample. Due to the impact of COVID-19 however, it was decided, upon discussion with key clergy and the author's academic supervisor, that the questionnaire should

close early. Despite initial interest, as the events of COVID-19 took hold, questionnaire responses dwindled, and eventually ceased. It was mutually agreed that due to the unprecedented additional psychosocial-spiritual demands created by COVID-19, the questionnaire may be perceived as an undesirable added burden on clergy. Moreover, it was feared that the extraordinary and unique pressures of the period may produce results that were not reflective of clergy health and wellbeing during 'normal' times additionally having limited applicability beyond this period. Data collection therefore ceased on 26th March 2020, coinciding with the start of the first UK lockdown.

3.3.4 Analytical Approach

To address the aims of this study, a two-fold approach was taken. On measures for which published threshold scores are available, descriptive statistics (means and standard deviations) were calculated. This included the measures of body mass, sleep quality, burnout, spiritual health, mental wellbeing, and work-related rumination. These scores were compared to data and norms from the general adult population. For other items, frequencies and percentages were calculated (e.g., social health items) and, where available, percentages were compared with UK population data. Findings were interpreted and compared, in the discussion section, to the extant trans-denominational UK and international clergy literature, describing the profile in the wider clergy context.

3.4 Questionnaire Measures

The questionnaire was divided into eight sections aiming to capture data across several demographic, health and wellbeing domains. Six widely used and validated multi-item measures of health and wellbeing were selected due to their use within

published UK occupational psychology research and thus available adult population data with which to compare findings.

3.4.1 Consent Questions

The questionnaire began with eight standardised consent questions for online questionnaires, set by the University of Nottingham ethics committee (see section 3.5 for all ethical considerations).

3.4.2 Occupational and General Demographic Data

These sections included six items regarding level of leadership, denomination, size of congregation, rough location, years of service, and one screening question to ensure responses from UK church leaders only. Additionally, three demographic questions were included comprising gender, marital status, and age. These questions sought to describe the cohort and allow for stratification of findings according to these characteristics. These items and characteristics are similar to those used in UK and international clergy research (Hileman, 2008; Lee & Iverson-Gilbert, 2003; Proeschold-Bell et al., 2017; Rolph et al., 2014; Rolph & Rolph, 2008).

3.4.3 Working Hours

As some clergy have definitive contracted hours and others have more fluid working time expectations, this question was split into two avenues. Initially participants were asked if they have contracted working hours, by a ‘yes’ or ‘no’ response. Participants were then taken to three designated questions exploring the number of hours worked in either their ‘contracted’ or fluid ‘expected’ hours.

As discussed in Chapter two, US research shows clergy willingly working excessive ‘on-call’ hours and spending substantial time in other unpaid work-related activities (Lifeway Research, 2015). Three items were therefore used to gauge the number of hours in activities relating to ministry: How many hours per week in ‘expected’ or ‘contracted’ paid work activities, how many hours on call, and how many hours in unpaid additional activities (e.g., house group). Answer options were offered on Likert scale in four-hour bands from one hour to >61 hours.

3.4.4 Spiritual Health

Proeschold-Bell et al. (2014) state that measuring clergy spiritual wellbeing has been largely neglected in the literature, yet this is an important area to consider as positive spiritual wellbeing is shown to be a protective factor against depressive symptoms in clergy (Milstein et al. 2020). Amongst the available measures in clinical and psychological research, no agreed primary measure exists (Monod et al., 2011, p. 1348). Many of the tools in use are also narrow in their search (e.g., exploring spiritual coping, or spiritual needs) neglecting the place of spiritual health as a general health facet. The freely available Spiritual Health and Life Orientation Measure (SHALOM) (Fisher, 2010) however, builds upon the Spiritual Health in Four Domains Index (SH4DI [Fisher et al., 2000]) tool, condensing the measure to 20 items and rigorously validity testing the tool across populations and languages. The tool provides a reliable yet relatable tool for clergy to identify with (Fisher, 2014; Timmins & Caldeira, 2017). The tool explores spiritual wellness across four domains: personal, communal, environmental, and transcendental. The questionnaire asks the participant to reflect on five questions in each domain, rating each twice on a five-point scale for *current lived experience* of spiritual wellbeing, and how

important the item is for their *ideal state* of spiritual wellbeing (Appendix C). Two scores are generated for each item, and the dissonance between the scores is used as a guide to individual spiritual health. The tool can be further subdivided into the four domains as follows:

Personal items - five, nine, 14, 16, 18

Communal items – one, three, eight, 17, 19

Environmental – four, seven, 10, 12, 20

Transcendental – two, six, 11, 13, 15

Comparing the lived experience to the individual ideals, calculating the dissonance between the two, indicates a level of perceived individual spiritual wellness.

3.4.5 Self-rated Health

Self-rated health measures are widely accepted in the UK and often used to explore the perceptions of individuals against more rigorous measurements (e.g., sedentary behaviour, disease risk, biomarkers etc.) (Chaparro et al., 2019; Kivimäki et al., 2004; ONS, 2019a; Wilson et al., 2019). Self-rated health was used in this study to gauge the knowledge and perceptions of participants' health with other questionnaire measures e.g., SHALOM dissonance and self-rated spiritual health.

Self-rated health data was collected across three health domains: spiritual, mental, and physical. Participants were asked in a single item for each "In general, how would you rate your (spiritual, mental or physical) health?" Five options were available 'Excellent, Very good, Good, Fair, and Poor'. This item's wording was taken from popular literature (e.g., Bennet & Lindström, 2018; Chaparro et al., 2019).

3.4.6 Mental Wellbeing

Mental wellbeing was assessed using the Warwick-Edinburgh Mental Wellbeing Scale (Warwick Medical School, 2021). To minimise questionnaire completion time, the short seven item SWEMWBS version was used in preference to the full 14-item version. This tool was selected due to its accuracy, validity, widescale international use, and positively worded questions. Despite the positive wording of the measure, and its focus on mental wellbeing, it has been benchmarked with common depression and anxiety scales (PHQ-9 and GAD-7) (Shah, 2020). This makes the short seven-item measure an ideal gauge of both mental health and wellbeing.

SWEMWBS asks participants to describe their perceptions over the past two weeks in seven statements e.g., 'I've been feeling optimistic about the future', rating their experience on a five-point scale 'None of the time, Rarely, Some of the time, Often, and All of the time' (Stewart-Brown et al., 2009). Scores are given from one to five and totalled to provide an overall score. As SWEMWBS is a shortened version of WEMWBS, raw scores must be transformed to a metric score using the table provided by the measure's authors (Stewart-Brown et al., 2009).

UK population samples provide a mean score of 23.5 (*SD* 3.9) (Ng Fat et al., 2017). It was determined that a low mental wellbeing range sits $\leq$19.5 and high wellbeing sits $\geq$27.5, with medium wellbeing sitting between these ranges (Ng Fat et al., 2017). With reference to the standardised PHQ-9 and GAD-7 depression and anxiety scales, scores $\geq$21 suggest no presence of depression or anxiety, scores of 18-20 indicate possible depression or anxiety, scores of $\leq$18 indicate likely depression or anxiety (Shah, 2020).

3.4.7 Clinical Supervision Opportunities

Although there is no single definition for clinical supervision, the Health and Care Professionals Council (2021, para. 1) state, "…at its core, supervision is a process of professional learning and development that enables individuals to reflect on and develop their knowledge, skills, and competence, through agreed and regular support with another professional." Supervision, and / or talking therapies for debriefing around the role not only support the individual but aim to improve the quality of care that is provided to service users (in this case, congregants) (Health & Care Professions Council, 2021). Given the counselling style expectations in many ministry roles (Barnett et al., 2007) and the potential for harmful congregant 'toxic' approaches to their clergy (Proeschold-Bell et al., 2011) levels of support in the form of clinical supervision provision were assessed in this study using a single item.

Participants were asked if they have the opportunity for regular clinical supervision, and given the options of: 'No, Yes – self-funded, Yes – Church funded, Yes – funded by an outside agency, and Yes – I have the opportunity but I do not use this service'.

3.4.8 Work Related Rumination

Due to the intense work hours and way of life expectations on clergy (Baptists Together, 2011, p. 3; Lifeway Research, 2015) work related rumination was assessed. Concerning work related rumination patterns arise when thinking about work becomes uncontrollable or affects an individual's health and wellbeing (Cropley et al., 2016, p. 2). Rumination may, in some circumstances, however, be positive and aid in problem solving (Cropley, 2015). Therefore, positive and negative ruminative thoughts were assessed using the validity tested and reliable

Work Related Rumination Questionnaire (WRRQ) (Cropley et al., 2012; Cropley & Collis, 2020; Querstret et al., 2016; Syrek et al., 2017). This 15-item measure, assesses rumination across three categories: problem solving rumination, detachment, and affective rumination.

This measure asks participants' current feelings on a set of 15 items with five possible responses, rated one to five e.g., 'Are you troubled by work-related issues when not at work?', 'Very seldom, Seldom, Sometimes, Often, Very often or always' (Cropley et al., 2012). Low rumination scores across the three sub-categories range between five and 10, medium between 11 and 19, and high rumination scores range between 20 and 25 (Cropley, 2015).

3.4.9 Social Health

Due to the known complexities in clergy social health expression and maintenance (Graveling, 2018a; Jenkins, 2018; Larson, 2020) two single item questions were included. Measures of social health were taken from the large scale repeated European Social Survey (European Social Survey European Research Infrastructure [ESS ERIC], 2018). The first single item asked participants how often they met socially with friends, seven possible answers were provided: 'Never, Less than once per month, Once per month, Several times per month, Once a week, Several times a week, Every day'. The second item asked, by answer of yes or no, if participants had anyone with whom they could discuss their intimate and personal matters with.

3.4.10 BMI

BMI is a widely accepted method used in global health to assess an individual's body weight to height ratio, it assesses if the individual carrying too

much weight for their height, and given their described lifestyle, if this extra weight is likely to be fat or muscle (NICE, 2022). This questionnaire asked participants to provide their height and weight (in metric or imperial units) their BMI was calculated at data cleaning using a standard BMI calculation chart (British Heart Foundation, n.d.).

The NICE (2022) guidelines were followed regarding scoring:

Underweight – scores <18.5

Healthy weight – scores between 18.5 and 24.9

Overweight – scores between 25 and 29.9

Obese – scores between 30 and 39.9

Severely obese – scores ≥40

3.4.11 Physical Activity

When exploring leisure time physical activity, it is useful to consider length of time, intensity, and number of days in which the activity is carried out. The NHS (2021c) recommends strengthening activities on at least two days per week, and at least 150-minutes of moderate intensity (or 75-minutes of vigorous intensity) activity spread over four to five days per week.

The validated Nordic Physical Activity Questionnaire-short (NPAQ- short [Danquah et al., 2018]) which combines moderate and vigorous physical activity, asks participants on a typical week how much time they spend in moderate and vigorous physical activity, recording sessions that last over 10-minutes. This study, in response to some participant comments during piloting, expanded answer options from the original measure's five potential hour and minute bands, to 10-minute

increments starting at zero to ≥150-minutes. Additionally, this study asked how many days per week participants engaged in this type of exercise.

Strengthening exercises are important throughout the lifespan to maintain muscle and bone strength (Department of Health and Social Care, 2019; Mayo Clinic Staff, 2023). Although no strict time guidelines are given, it is recommended that all major muscle groups are worked twice a week, where the muscles become temporarily fatigued (circa 20 – 30-minutes) (Davies et al., 2019; Mayo Clinic Staff, 2023). A second item, therefore, following the same answer options as moderate and vigorous physical activity (the amount of time and number of days) was included for strengthening exercises.

3.4.12 Sleep Quality

Quality sleep is an essential, but often neglected, component of health and wellbeing (Pacheco & Singh, 2023; Summer, 2022). One in six UK adults are surviving on an unhealthy six hours or less of sleep per night, and one in three reports sleeping seven hours per night (Smith, 2020). Waking impairments, accidents and injuries can be seen at this level of sleep (e.g., car accidents) (Sprajcer et al., 2022). This study, therefore, sought to profile the quality and possible subsequent day time fatigue in this cohort.

The Basic Nordic Sleep Questionnaire-short (BNSQ – short) provided a validated, reliable, and well cited measure to analyse this cohorts' sleep quality. The full measure consists of 21 items (Partinen & Gislason, 1995) but was successfully shortened to a five-item measure by Dalgaard et al. (2014). The measure asks participants to rate their experience of five items in the past four weeks e.g., Have you had difficulties falling asleep? Five possible responses are offered, rated one to

five: ‘Never or almost never, Less than once per week, On 1-2 days per week, On 3-5 days per week, Every night or almost every night’. Scores are totalled with possible ranges from 5-25, the higher the score the greater the presence of dysregulated sleep.

Although there are no strict score bands for this measure, Dalgaard et al. (2014) in their study of workers experiencing occupational stress, cited 13.73 as a mean score in their treatment group, and 14.46 in their untreated control group at four-month follow up. These figures may be used as a guide in addition to analysis of the volume of participants experiencing regular difficulties with sleep quality or daytime fatigue.

3.4.13 Past Medical History

Certain long-term health conditions are associated with increased mortality risk, co-morbidities, and reduced quality of life (NHS Digital, 2019a, 2019b). To comprehensively profile the whole health of clergy, obtaining a picture of underlying illness, disease, and disease risk is advantageous.

Participants were asked to select from a range of common disabling physical health conditions ticking all that apply, a free text ‘other’ option was also provided. The items listed were known common health conditions, largest causes of health impairment, working days lost, disability, and death. They were selected from the latest UK data on disability, disease, and occupational health and wellbeing (Allergy UK, n.d.; Department of Health, 2014; Harvard Health Publishing, 2022; NHS, 2021a; NHS Digital, 2019a; 2019b; ONS, 2019b; Schat et al., 2005).

3.4.14 Nutritional Intake and Awareness

Several clinical measures exist to assess nutritional intake, however, these are usually used for at risk patients to ensure optimal nutritional intake during illness and recovery. The assessment of dietary healthfulness in healthy adults is more challenging. The author sought the advice of Professor Langley-Evans, head of Biosciences at the University of Nottingham, used government guidelines (NHS, 2021b; Public Health England, 2016a, 2016b) the Whitehall II - Stress and Health Study (University College London, 2012) Diet Quality Index (INDDEX Project, 2018) and personal clinical knowledge as a registered healthcare professional to pose questions that would assess both nutritional intake and knowledge.

This section comprised three questions. The first question asked participants to select their usual type of diet e.g., 'No restriction, Flexitarian, Vegan, Pescatarian' etc. This was an assessment of knowledge on healthful nutritional choices (Song et al., 2016; Tomova et al., 2019) and bio-spirituality (e.g., that observed by long living Seventh Day Adventists) (Nath, 2010).

The second question sought to assess knowledge, and posed four statements around knowledge of portion size, macro and micronutrients, government guidelines, and processed food consumption e.g., 'I am aware of the saturated fat, sugar, salt guidelines and generally stick to them'. Five response options were provided: 'Strongly agree, Somewhat agree, Neither agree nor disagree, Somewhat disagree, and Strongly disagree'.

The final question, 11 items, asked participants over the past 12 months on average how much they consumed the items listed. The items included red meat, wholegrains, heavily processed foods, added salt, added sugar, and fruits and vegetables etc. The 10 answer options aligned with the Whitehall II - Stress and

Health Study (University College London, 2012) and included: ‘Never, Less than once / month, 1-3 per month, Once a week, 2-4 per week, 5-6 per week, Once per day, 2-3 per day, 4-5 per day, 6+ per day’.

3.4.15 Burnout

To assess burnout, this study used the 16 item Oldenburg Burnout Inventory (OLBI) (Demerouti et al., 2001) that measures disengagement and exhaustion. The OLBI was selected in preference to the widely used Maslach Burnout Inventory (on which the FBI is based) based on length (16 items versus 22) and cost (the OLBI is freely available without a royalty payment to the copyright holder). The components of the Maslach Burnout Inventory are very similar to the OLBI, however, the OLBI is preferred by some due to the acknowledgement of both the physical and cognitive elements of the exhaustion factor (Nwosu et al., 2020). Additionally, the ‘psychometric balance’ has been praised due to the use of both positive and negative wording (e.g., ‘I always find new and interesting aspects in my work’, and ‘Sometimes I feel sickened by my work tasks’) (Demerouti et al., 2003; Nwosu et al., 2020, p. 2). Finally, the convergent validity of the OLBI with the Maslach Burnout Inventory has been tested and supported (Demerouti et al., 2003).

Eight items each cover disengagement and exhaustion. Four possible answer options are provided, scored one to four (seven items are reverse scored): ‘Strongly agree, Agree, Disagree and Strongly disagree’. The items relating to either disengagement or exhaustion are totalled, and the mean score is used to gauge unhealthy levels in each domain. A mean score $\geq$2.25 indicates high levels of exhaustion, and scores of $\geq$2.1 indicate high levels of disengagement (Peterson et al., 2008).

Scores can be further categorised as follows (Peterson et al., 2008):

Non-burnout - Low exhaustion and low disengagement

Disengaged - Low exhaustion and high disengagement

Exhausted - High exhaustion and low disengagement

Burnt-out - High exhaustion and high disengagement

3.4.16 Financial Health

As it is known that some clergy are bi-vocational (Samushonga, 2019) a single item was included asking if participants hold any secondary employment to supplement their church income. Three answer options were provided: 'Yes, I have a second job where I am employed, Yes, I am self-employed in another role; and No, I do not have any other form of employment'.

Additionally, a further single item was adopted from a highly cited British article exploring the relationship between subjective financial wellbeing and health, namely personal economic strain (Arber et al., 2014, p. 14). The item asked participants to consider their weekly or monthly income and rate their ability to make ends meet. Four options were given: 'Very easily/ easily, Fairly easily, With some difficulty, or With difficulty/ with great difficulty'.

3.4.17 Holistic Health Comprehension and Perceived Permission to Self-care

Two final questions were included to align with data produced in Proeschold-Bell et al.'s (2011) theoretical model of clergy health. This work identified the complex web of knowledge, skills, support, and environmental determinants that influence a clergy members self-care adherence.

The first two item question asked if participants feel they have permission and support to self-care by their church leadership, and secondly by their

congregation. Four answer options were available: ‘Yes always, Yes sometimes, Only on rare occasions, and No never’. The second question sought to gauge individual knowledge on holistic health as it relates to self-care and ministry. The question asked if clergy felt that caring for their physical and mental health was an important factor for ministry. Four answer options were available: ‘Yes definitely, Yes, but not as important as my spiritual health, Not really, only when I have time, energy etc., and Not at all important’.

3.5 Ethical Considerations

3.5.1 Institutional Approval

Ethical approval for this study was granted on the 2nd December 2019 by the University of Nottingham, faculty of Medicine and Health Sciences (reference DPAP -2019-0393-2) (Appendix P).

3.5.2 Consent

Consent was obtained at the start of the questionnaire. Participants could not proceed without acknowledging eight standardised consent questions approved by the University of Nottingham, faculty of Medicine and Health Sciences ethics committee. These questions confirmed the participants age, their awareness of where to seek support if they had study related questions, alongside confirming they had read and understood the study outline, procedure, expectations, and voluntary nature of the study.

3.5.3 Risk of Coercion

To avoid any undue pressure or implied coercion, advertising materials were worded neutrally. Generic flyers (Appendix Q) were designed and distributed via social media and through links with the BUGB. The wording and imagery selected was clear, concise, informal, and non-judgemental. It was clear in email and social media advertising that participation was voluntary.

3.5.4 Confidentiality and Anonymity

Confidentiality and anonymity were maintained through the data collection processes employed and the use of Online Surveys (Online Surveys, n.d.). Participants did not divulge any identifying data and submitted all responses through the secure online questionnaire hosting site. Due to the nature of the questionnaire design, once submitted, it was not possible to identify any specific individuals. This process was clearly outlined in the participant information sheet which was attached in the consent section at the start of the questionnaire.

3.5.5 Further Support

Participants were provided with a list of support agencies at the end of the questionnaire. The contact details of agencies including Mind, Crossline, and the NHS website, were provided should participants feel the need to discuss or explore any of the health and wellbeing matters raised in the questionnaire.

3.6 Results

3.6.1 Demographic Characteristics

As detailed in section 3.3.1, the study was promoted through various channels, and it is impossible to know what proportion of the approximately 1,400 UK Baptist clergy viewed the invitation to participate. As such, a response rate cannot be determined.

Participants' socio-demographic characteristics are displayed in Table 3. Fifty-five respondents completed the questionnaire. Participants ranged from 21 - 69 years old, with the mean age of 34 (*SD* = 11.15). The gender split in this sample (67% male), is similar to that of Proeschold-Bell et al.'s (2017) study where 69% of their participants were male. Similarly, in both this study and Proeschold-Bell et al.'s (2017) work, 89% of participants were married.

Table 3
Participant Sociodemographic Characteristics

	N (%)
Gender	
Male	37 (67)
Female	18 (33)
Age	
≤29	2 (<5%)
30-39	11 (20)
40-49	10 (18)
50-59	20 (36)
60-69	12 (21)
Marital status	
Single	4 (7)
Married	49 (89)

Divorced	2 (<5%)

Note. Percentages have been rounded to the nearest whole number.

3.6.2 Occupational Characteristics

Participants' occupational-demographic characteristics are displayed in Table 4. Most respondents (85%) identified as the main pastor in their church, while a further 9% reported being an associate pastor. The remainder were youth pastors (<5%) and one person was a 'minister to ministers'.

Respondents reported having a mean of 16 years (*SD* = 12.09) of professional experience, and 93% of clergy served congregations of ≤200, with a majority serving an urban community.

Table 4
Participant Occupational Characteristics

	N (%)
Role	
Main minister (e.g., senior pastor)	47 (85)
Co-minister (e.g., associate pastor)	5 (9)
Youth pastor / leader	2 (<5%)
Other	1 (<5%)
Years of experience	
≤5	13 (24)
6 -10	13 (24)
11-20	12 (22)
21-30	9 (16)
31-40	8 (14)
Congregation size	
50 or less	19 (34)
51-100	20 (37)
101-200	12 (22)

201-300	1 (<5%)
301-400	1 (<5%)
401-500	1 (<5%)
More than 501	1 (<5%)
Community style	
Rural	9 (16)
Urban	26 (47)
Mixed	20 (37)

Note. Percentages have been rounded to the nearest whole number.

3.6.3 Descriptive Statistics and Internal Consistency

Descriptive statistics and scale reliability coefficients are displayed in Table 5. The Cronbach's alpha coefficient was used as a measure of internal consistency for multi-item scales, with a coefficient of $\geq$.7 indicating acceptable internal scale reliability (Morgan et al., 2013). Using this threshold, the BNSQ-short α fell just below this threshold at .69.

The detachment sub-scale of the Work-Related Rumination Questionnaire was eliminated due to a coefficient of .32. Selective use of the questionnaire's sub-scales is consistent with the approach of the measure designers, who have selected from the three sub-scales, eliminating elements to provide the most meaningful analysis (Cropley et al., 2016; Cropley et al., 2017; Firoozabadi et al., 2018; Querstret et al., 2017).

Table 5
Descriptive Statistics and Internal Reliabilities

Measure	Items	Observed Range (possible range)	*M*	*SD*	α
SHALOM[a,e] – Part A	20	72 – 98 (20 – 100)	83.9	6.4	.78
SHALOM[e] – Part B	20	41 – 96 (20 – 100)	68.5	10.9	.90
SHALOM[e] – difference	N/A	0 – 36 (0 -99)	15.4	8.99	N/A
SWEMWBS[b]	7	16.4 – 35 (7 -35)	21.7	3.5	.86
Affective rumination	5	5 – 25 (5 – 25)	16.2	5.3	.96
Problem-solving rumination	5	10 – 25 (5 – 25)	17.2	3.0	.72
Detachment	5	8 – 20 (5 – 25)	14.3	2.2	.32
BNSQ[c] Short	5	6 – 25 (5 -25)	14.4	4.4	.69
OLBI[d] – Disengagement	8	1 – 3.25 (1 – 4)	2.16	.48	.73
OLBI - Exhaustion	8	1 – 3.75 (1 – 4)	2.51	.52	.83

a - Spiritual Health And Life-Orientation Measure (SHALOM)
b - Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS)
c - BNSQ - Basic Nordic Sleep Questionnaire (BNSQ Short)
d - Oldenburg Burnout Inventory (OLBI)
e - Partial listwise deletion was used on the SHALOM data, see section 3.9.5.

3.6.4 Spiritual Health

SHALOM relies on participants providing two scores. A third score is calculated indicating the dissonance between their ideal state of spiritual wellbeing and their current lived experience. Results are displayed in Table 6. Lived experience and ideal spiritual wellbeing totals produced a mean difference of 15.4 with an observed range of 0-36 (possible range 0-99). This is substantially higher than other high-pressure roles such as palliative care doctors, who showed a dissonance of 1.5 (Fisher & Brumley, 2012).

SHALOM can be further sub-divided in to four categories of spiritual wellbeing, personal, communal, environmental, and transcendental. Other than the environmental domain, there appears a substantial difference between participants ideals and their current lived experiences. Previous studies that have used this measure (with participants both with and without a declared religious orientation) have found a difference, however, that difference has been small (Fisher, 2012; Fisher & Brumley, 2008, 2012). A tentative takeaway, therefore, from this cohort may be that their perceptions of ideal spiritual wellbeing may be unattainable or unrealistic when considering their lived experiences, creating a potential spiritual wellbeing disharmony. To ascertain a deeper understanding of the general dissonance, suitability, accuracy, and acceptability of this measure further research among UK clergy would be advantageous.

Table 6
The Dour Domains of SHALOM

	Ideal *M (SD)*	Current lived experience *M (SD)*	Dissonance
Personal	22 (2)	17.8 (3.7)	4.2
Communal	23.3 (1.8)	18.9 (3.2)	4.4
Environmental	14.4 (4)	13.8 (4.4)	0.6
Transcendental	23.8 (1.4)	18 (3.2)	5.8

3.6.5 Mental Wellbeing

Mental wellbeing was gauged using SWEMWBS, an item regarding psychological support, and one item regarding self-rated health. The mean wellbeing score ascertained from SWEMWBS in this cohort was 21.7 (*SD* = 3.5). This score falls below the national average of 23.5 (*SD* 3.9) (Ng Fat et al., 2017). As per the tool's instructions, there are no definitive score ranges for wellbeing. The tool, however, uses the mean population score and standard deviation to estimate high wellbeing at >27.4 and low wellbeing at <19.6 (Warwick Medical School, 2021) medium wellbeing sitting in between those scores. Based on this, it can be determined that the current study's clergy fall below the national average and sit at the lower end of medium (Ng Fat et al., 2017). Overall, 16 participants (29%) sat in the low wellbeing range and three participants (5%) sat in the high wellbeing range. With reference to the PHQ-9 and GAD-7 depression and anxiety scales, therefore, 29% of this cohort may be experiencing depression and / or anxiety (Shah, 2020). Notably at the item level of SWEMWBS (Table 7) 16 (29%) stated they have never or rarely been feeling relaxed, and 11 (20%) stated they have never or rarely been

feeling close to others over the past two weeks. Additionally, when asked to self-rate their mental health, 24 (44%) participants in this study self-rated their mental health as poor or fair, and 31 (56%) rated their mental health as good, very good, or excellent.

Table 7
SWEMWBS Item Level Responses

SWEMWBS items	Number of participants citing in the last two weeks, they have never or rarely been: *n* (%)
Feeling optimistic	4 (7)
Feeling useful	7 (13)
Feeling relaxed	16 (29)
Dealing well with problems	7 (13)
Thinking clearly	2 (4)
Feeling close to others	11 (20)
Able to make up own mind	1 (2)

Note. Percentages have been rounded to the nearest whole number.

Due to the known stressors of the role, clergy mental health concerns internationally, and varied role expectations, participants were asked if they had access to psychological support. Results are shown in Table 8. It is notable therefore that only 11 (20%) had access to church or outside agency funded support. Six (11%) participants were seeking self-funded support, and 38 (69%) stated they did not have any access to psychological support.

Table 8
Phycological Support

Do you have the opportunity for regular clinical supervision, counselling, or other talking therapy for reflection regarding your role?	*N* (%)
Yes – self-funded	6 (11)
Yes – church funded	5 (9)
Yes, funded by an outside agency	1 (<5%)
Yes, I do have the opportunity but do not use it	5 (9)
No	38 (69)

Note. Percentages have been rounded to the nearest whole number.

The SWEMBS score, self-rated health, and access to support suggest there are a significant proportion of clergy in this study with lower mental health and wellbeing, and there appears a deficit in support being accessed and / or provided. This highlights the necessity for future research, interventions, and evidenced based support strategies, to support clergy in the facet of mental health and wellbeing.

3.6.6 Physical Health

Clergy physical health was measured using a combination of tools, measures and self-rated items including, BMI, nutritional status, past medical history, physical activity, sleep, and self-rated health.

3.6.6.1 Past Medical History.

Participants were asked to select any past physical medical history against common medical problems linked with poor quality of life, related illness, and disease. Results (Table 9) show 27 (49%) participants stated they did not have past or current physical health concerns, while three (6%) voluntarily disclosed mental

health issues. Amongst those with physical health issues, the most commonly cited were hypertension (nine, 16%), and musculoskeletal issues (six, 11%). These figures are notable in terms of potential absenteeism. In an analysis of working days lost in the UK in 2018, 19.7% were due to musculoskeletal issues, and 3.4% were due to hypertension (ONS, 2019b).

The current study showed 28 (51%) had a longstanding medical condition. In a 2018 review of 8,178 adults, 43% of UK adults were shown to have a longstanding medical condition (physical and mental) (Moody, 2019) this is slightly lower than the current study. The most commonly cited concerns in this same 2018 review indicated that 17%, cited musculoskeletal issues (higher than the current study's findings) and 11% cited heart and circulatory issues (substantially lower than the current study's findings) (Moody, 2019). The current study's data, therefore, indicate similar common health concerns to the UK adult population, with some greater health deficits in certain conditions and number of presenting health issues.

Table 9
Medical History, Current, and Chronic Conditions

In the last 5 years, has your GP (or another physician) diagnosed you with any of the following conditions?	*N* (%)
None	27 (49)
High blood pressure (hypertension)	9 (16)
Musculoskeletal issues (osteoarthritis, joint disorders, gout, back pain, repetitive strain injury)	6 (11)
Chronic fatigue and immune disorders	4 (7)
Gastrointestinal issues (e.g., IBS)	4 (7)
Migraines or frequent headaches	4 (7)
Respiratory disease (COPD, asthma, obstructive sleep apnoea)	4 (7)
High cholesterol	3 (6)
Stomach issues, pain bloating, nausea, vomiting, increased or decreased appetite	3 (6)
Skin conditions such as Eczema	2 (<5%)
Type 2 diabetes	2 (<5%)
Coronary heart disease / cardiovascular disease (CHD)	1 (<5%)
Gallstones	1 (<5%)
Stroke or mini stroke (CVA or TIA)	1 (<5%)
Other:	
Anxiety and depression	1 (<5%)
Bipolar disorder	1 (<5%)
Depression	1 (<5%)
Hypothyroidism	1 (<5%)

Note. Percentages have been rounded to the nearest whole number.

3.6.6.2 Body Mass Index.

BMI results can be observed in Table 10. Only 16 (29%) participants sat in the normal weight range, while 20 (36%) were overweight, 17 (31%) were obese and two (<5%) were severely obese (ranges as per NICE guidelines [2022]). The average BMI for this cohort was 28.3, higher than the UK mean in 2018, which was 27.5

(NHS Digital, n.d.). Due to the nature of calculating the mean, outliers at the higher end of the scale may impact the mean, and thus interpretation of the results for the cohort as a whole. However, when using partial listwise deletion for the two largest scores >40, the cohort's mean BMI still remains higher than the national average at 27.8. Whilst excluding the two largest scores, 67% were in the overweight or greater range, higher than national figures where 64% of the UK population sat in this range (NHS Digital, 2019c). Overall, these data indicate a potential height / weight ratio issue in this cohort.

It can be argued that BMI is not an exact science due to the inability of the measurement to differentiate between muscle and fat. It does, however, act as an indicator (in combination with other measures and lifestyle factors) for risk of illness and disease, including type II diabetes, hypertension, heart disease, stroke, obstructive sleep apnoea, metabolic syndrome, fatty liver disease, osteoarthritis, and other concerns (National Institutes of Health, 2018).

Table 10
BMI

Measure	Range	*M*	*SD*	Normal range *N* (%)	Overweight *N* (%)	Obese *N* (%)	Severely obese *N* (%)
Body Mass Index	20.8 – 47.2	28.3	5.2	16 (29)	20 (36)	17 (31)	2 (<5%)

Note. Percentages have been rounded to the nearest whole number.

3.6.6.3 Nutrition.

The nutritional intake healthfulness in this investigation was varied. Thirty-nine (71%) stated they consumed an unrestricted diet, including meat poultry, and eggs, and 44 (80%) stated they consumed these items ≥twice per week (Table 11). Red and processed meats are associated with bowel cancer (NHS, 2021b) and animal protein consumption increases the risk of hypercholesterolaemia and hypertension due to the saturated fat content (NHS, 2021b). NHS guidelines, therefore, suggest varying protein intake including plant sources such as beans and pulses (NHS, 2021b).

Despite the known health benefits of plant-based diets and the significant increase in vegan dietary adherence between 2014 – 2019 (The Vegan Society, n.d.) only three (≤5%) respondents stated they fully or partially restricted animal products (vegetarian or vegan). In the current study, 12 (22%) stated they followed a flexitarian diet, yet UK data indicate that around half of the population are set to follow a flexitarian diet by 2025 (Hughes et al., 2019) indicative that this cohort are falling behind UK nutritional trends.

Table 11
Dietary and Nutritional Choices

Usual diet	*N* (%)
No restriction (standard unrestricted diet, consuming meat, fish, poultry, dairy, and eggs etc.)	39 (71)
Flexitarian (consumes meat, fish, poultry, dairy, and eggs but significantly restricts consumption, e.g., 'meat-free Mondays')	12 (22)
Lacto-ovo vegetarian / standard vegetarian (does consume eggs and dairy, but avoids meat, fish, and poultry)	2 (<5%)
Vegan / fully plant based (avoids all animal-based products such as meat, fish, poultry, eggs, and dairy)	1 (<5%)
Other:	
Lactose intolerant	1 (<5%)

Note. Percentages have been rounded to the nearest whole number.

Table 12
Dietary Component Consumption Volume

Measure	Never	< once per month	1-3 times per month	Once per week	2-4 times per week	5-6 times per week	Once per day	2-3 times per day	4-5 times per day	6 + times per day
						N%				
Meat, poultry, and eggs	0	1 (<5%)	3 (6)	7 (13)	23 (42)	12 (22)	6 (11)	2 (<5%)	0	1 (<5%)
Oily fish	4 (7)	6 (11)	14 (25)	26 (48)	5 (9)	0	0	0	0	0
Meat and protein alternatives	16 (29)	11 (20)	5 (9)	12 (22)	7 (13)	2 (<5%)	1 (<5%)	0	1 (<5%)	0
Wholegrains	0	1 (<5%)	1 (<5%)	13 (24)	11 (20)	9 (16)	13 (24)	4 (7)	2 (<5%)	1 (<5%)
White refined grains	6 (11)	9 (16)	7 (13)	12 (22)	11 (20)	3 (6)	4 (7)	3 (6)	0	0
Cheese	1 (<5%)	2 (<5%)	5 (9)	8 (15)	14 (25)	18 (33)	6 (11)	0	0	1 (<5%)
Heavily processed foods and / or deep-fried foods	6 (11)	11 (20)	15 (27)	7 (13)	7 (13)	4 (7)	3 (6)	2 (<5%)	0	0
Sugar in drinks or desserts	33 (60)	3 (6)	2 (<5%)	2 (<5%)	4 (7)	2 (<5%)	5 (9)	1 (<5%)	1 (<5%)	2 (<5%)
Salt during or after cooking	13 (24)	7 (13)	2 (<5%)	4 (7)	14 (25)	1 (<5%)	9 (16)	4 (7)	0	1 (<5%)
Fruits	0	0	2 (<5%)	1 (<5%)	6 (11)	3 (6)	13 (24)	22 (40)	5 (9)	3 (6)
Vegetables	0	0	0	0	2 (<5%)	4 (7)	11 (20)	29 (53)	4 (7)	5 (9)

Note. Percentages have been rounded to the nearest whole number.

It is suggested that the most healthful intake of fruit and vegetables is two portions of fruits and three portions of vegetables per day (Godman, 2021). The slight variation in consumption arises from the nutritional benefits, particularly of leafy vegetables (e.g., kale) where the whole plant, leaves, stem, bulb (and sometimes roots) are consumed, as opposed to the pollinated flowers in fruits (Meeks & Sherrell, 2021). In the current study 12 (22%) were consuming more fruit than vegetables, and 24 (44%) were consuming an equal amount of fruit and vegetables (Table 12). The overall fruit and vegetable intake was higher than the national average however, where only 28% of UK adults were consuming the recommended five portions per day (NHS Digital, 2018) only six (11%) were consuming fruit and / or vegetables once per day only.

Nutritional knowledge varied in this cohort and did not appear to correlate with BMI findings. Thirty-eight (69%) stated they agreed (strongly or somewhat) with the statements around consuming an adequate portion size, and 32 (58%) stated they agreed (strongly or somewhat) that they were aware, and stick to, the dietary guidelines regarding salt, fat, and sugar (Table 13). Yet, only 16 (29%) sat in the normal weight range on BMI calculation. Although, BMI does not account for muscle mass, these data, for some, are suggestive of a nutritional knowledge / action imbalance.

A nutritional knowledge deficit is further supported by participants' statements around white refined grains, ultra-processed foods (UPF), added sugar and salt consumption. Twenty-one participants stated they consumed white refined grains $\geq$2 times per week. These grains are known to increase blood sugar and so risk for diabetes and other health issues (Cleavland Clinic, 2020). Similarly, health risks are potentially increased with added salt, sugar, and UPF, fifteen (27%)

participants add sugar to their drinks or desserts, 29 (53%) add salt to their food, and 16 (29%) consume UPF ≥2 times per week.

Table 13
Nutritional Awareness

Measure	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
			N (%)		
On a typical day I consume sensible food portions for my gender, e.g., not filling the plate to the edges.	9 (16)	29 (53)	8 (15)	9 (16)	0
I am aware of where I get my basic nutrients from such as iron, protein, B12, calcium, fibre, vitamins C and D, and fatty acids.	15 (27)	23 (42)	8 (15)	5 (9)	4 (7)
I am aware of the saturated fat, sugar, and salt guidelines and generally stick to them.	14 (25)	18 (33)	14 (25)	8 (15)	1 (<5%)
I (or my family), cook food from scratch, e.g. we do not use jar sauces or ready meals.	22 (40)	13 (23)	8 (15)	6 (11)	6 (11)

Note. Percentages have been rounded to the nearest whole number.

3.6.6.4 Physical Activity.

In the current cohort 10 (18%) participants stated they engaged in the recommended ≥150-minutes (NHS, 2021b) per week of moderate intensity exercise, five of these were in the over 60s age group (Tables 14 and 15). No participants under 45 stated they met the ≥150-minutes goal. These clergy data for physical activity show lower engagement than the UK adult population where one in six adults are achieving ≥150-minutes of moderate intensity exercise per week (Sport England, 2020).

Although the UK Chief Medical Officer's report (Department of Health and Social Care, 2019) suggests that adults may achieve health benefits by completing the 150-minutes in one or two sessions, to reduce the effects of sedentary lifestyles, spreading exercise over several days is still NHS recommended (NHS, 2021c). In the current study, 17 (31%) spread their exercise over the recommended four to five days per week (NHS, 2021c).

Thirty-four (62%) did not engage in any strengthening exercises, and only 11 (20%) met the recommendations of strengthening exercises on two or more days per week (NHS, 2021b). Notably, only one 60+ female participant met the strengthening exercise guidelines. Strengthening exercises are important for all genders across the life span, however, women during menopause may significantly benefit from strengthening due to reduced oestrogen production which can affect bone density and muscle mass (Mitchell, 2022; Public Health England, 2020).

Table 14

Time Engaged in Moderate Intensity Exercise and Strengthening Exercise

Measure	*0-minutes*	≤ 30-minutes	40 – 70-minutes	80 – 110-minutes	120 -149-minutes	≥2.5 hours
			N (%)			
Minutes per week of moderate – vigorous physical activity	4 (7)	12 (22)	15 (28)	10 (18)	4 (7)	10 (18)
Minutes per week of strengthening exercises	33 (60)	10 (18)	9 (16)	2 (<5%)	2 (<5%)	0

Note. Percentages have been rounded to the nearest whole number.

Table 15

Days Engaged in Moderate Intensity Exercise and Strengthening Exercise

Measure	0 days per week	1 day per week	2 days per week	3 days per week	4 days per week	5 days per week	6 days per week	7 days per week
				N (%)				
Moderate – vigorous physical activity	6 (11)	9 (16)	8 (15)	15 (28)	2 (<5%)	7 (13)	4 (7)	4 (7)
Strengthening	34 (62)	10 (18)	2 (<5%)	5 (9)	0	2 (<5%)	1 (<5%)	1 (<5%)

Note. Percentages have been rounded to the nearest whole number.

3.6.6.5 Sleep.

Mental Health UK (n.d.) states that one in five people are not getting sufficient sleep. Not only does lack of sleep affect mental wellbeing, but The Sleep Charity (2021) suggests dysregulated sleep can have harmful effects on the cardiovascular system and increases the risk of stroke, heart disease, type II diabetes, and inflammatory disorders. Dysregulated sleep, fatigue, and sleep quality was assessed using the BNSQ short measure. The mean score for this cohort was 14.4 (*SD* 4.4). Possible scores range from 5-25, with lower scores indicating no or few problems with sleeping. An intervention, using the BNSQ short, of workers experiencing occupational stress and absence, and undergoing cognitive behavioural therapy, cited their four month follow up score as 13.73 (Dalgaard et al., 2014). Notably the intervention's untreated control group's mean score was 14.46 (Dalgaard et al., 2014). Ergo, the current clergy mean BNSQ-short score is close to that of the control group's workers who were experiencing work related stress.

Additionally, the current study's results show 43 (78%) waking in the night at least once a week, 11 (20%) waking in the night three to five times a week, and 19 (35%) waking every (or almost every) night. In addition, 33 (60%) reported feeling excessively sleepy in the daytime at least once a week, and 20 (36%) reported feeling excessively sleepy ≥three days a week. Philips (2019) Global Sleep Survey found that 67% of adults wake in the night, and six in 10 adults experience daytime sleepiness >twice per week. These data suggest that the clergy in this study experience less refreshment and poorer quality sleep than global comparative adult populations.

3.6.6.6 Self-rated Physical Health.

Participants were asked to self-rate their physical health, results are shown in Table 16. Twenty-eight (51%) self-rated their physical health as fair or poor, while 27 (49%) self-rated their physical health as ≥good. This is lower than UK national averages where 69% of UK adult respondents stated they were in good health (ONS, 2019a).

Table 16
Self-rated Physical Health

Measure	Poor *N* (%)	Fair *N* (%)	Good *N* (%)	Very good *N* (%)	Excellent *N* (%)
Self-rated physical health	3 (6)	25 (46)	15 (27)	10 (18)	2 (<5%)

Note. Percentages have been rounded to the nearest whole number.

3.6.7 Social Health

Social health was measured through the lens of social contact and available emotional support, results are shown in Table 17. In this study, 46 (84%) stated they do have individuals with whom they can discuss their personal matters. This figure is slightly lower than UK survey data, where 97% stated they had this outlet (European Social Survey European Research Infrastructure [ESS ERIC], 2021).

No participants from this clergy cohort stated that they met socially with friends every day (13% of UK adults meet socially daily [European Social Survey European Research Infrastructure [ESS ERIC], 2021]). Most participants stated they have a social engagement several times a month. Conversely, several times a week was the most commonly cited frequency in UK population data (European Social Survey European Research Infrastructure [ESS ERIC], 2021). In the current study 17

(31%) clergy stated they met socially with friends ≥once a week, this is substantially lower than the 73% of UK adults who stated they met socially at this frequency (European Social Survey European Research Infrastructure [ESS ERIC], 2021). These figures are indicative of potentially low social wellbeing in this cohort.

Table 17
Social Health

Measure	Never *N* (%)	Less than once per month *N* (%)	Once a month *N* (%)	Several times a month *N* (%)	Once a week *N* (%)	Several times a week *N* (%)
How often do you meet socially with friends, relatives, or work colleagues?	1 (<5%)	13 (24)	10 (18)	14 (25)	11 (20)	6 (11)
	Yes *N* (%)	No *N* (%)				
Not including paid professionals, do you have anyone with whom you can discuss intimate and personal matters?	46 (84)	9 (16)				

Note. Percentages have been rounded to the nearest whole number.

3.6.8 Financial Health

In this study, 11 (20%) participants stated they had a second job to supplement their church income (Table 18). In 2019, 4% of the UK population had second jobs (ONS, 2020). Additionally, 13 (24%) clergy participants stated they had difficulty making ends meet, this figure is considerably higher than the 14.1% of the UK population who cited this difficulty (ONS, 2019a). The data collected in the current study are indicative of financial stress in some clergy participants.

Table 18
Financial Health

Measure	Very easily / easily *N* (%)	Fairly easily *N* (%)	With some difficulty *N* (%)	With difficulty / with great difficulty *N* (%)
Thinking of your household's total monthly or weekly income, is your household able to make ends meet?	19 (34)	23 (42)	11 (20)	2 (<5%)
	Yes, employed *N* (%)	Yes, self-employed *N* (%)	No *N* (%)	
Do you hold any other jobs to supplement your church income?	9 (16)	2 (<5%)	44 (80)	

Note. Percentages have been rounded to the nearest whole number.

3.6.9 Occupational Health

Occupational health and wellbeing were assessed in terms of working hours, work-related rumination, and burnout.

3.6.9.1 Working hours.

Participants cited varied working patterns and hours. Due to the nature of some clergy working contracts and role expectations, participants were asked to state if they had expected or contracted working hours. Additionally, the cohort were asked to estimate their average weekly hours in their primary role, work on call, and other expected but unpaid work (e.g., house groups, and church events). A breakdown of these hours can be viewed in Table 19.

Table 19
Working Hours

Measure	1-10	11-20	21-30	31-40	41-50	>51
			N (%)			
N=40 participants with **expected** working hours:						
Hours in paid work activities	2 (≤5%)	2 (≤5%)	3 (7)	11 (28)	13 (33)	9 (23)
Hours on call	5 (13)	3 (7)	4 (10)	3 (7)	0	25 (63)
Worked hours not part of expected hours	32 (80)	3 (7)	3 (7)	2 (≤5%)	0	0
N=15 participants with **contracted** working hours:						
Hours in paid work activities	0	3 (20)	4 (27)	4 (27)	2 (13)	2 (13)
Hours on call	1 (7)	1 (7)	1 (7)	0	2 (13)	10 (66)
Hours in work not part of contracted hours	9 (60)	4 (27)	2 (13)	0	0	0
The maximum stated weekly hours exceed 48 hours		Yes *n* (%)			No *n* (%)	
		33 (60)			22 (40)	

Note. Percentages have been rounded to the nearest whole number.

Most notably, 60% of clergy appear to work in their primary role and additional church activities in excess of the 48-hour weekly limit set out in the Working Time Directive (The Working Time Regulations, 1998). Additionally, 40% report working 51 hours or more (16% ≥ 61 hours). These stated full time working hours are significantly higher than the national average hours of 36.3 for full time workers in January – March 2020 (ONS, 2023). Additionally, 47% of respondents reported working over six hours or more in unpaid expected church activities per week. Over five billion UK workers report an average of seven and a half hours unpaid work every week (Trades Union Congress, 2019).

Of those who stated they had contracted working hours, 66% reported additionally being on call ≥51 hours or more (63% for those with expected hours). The notion of 'on call' being somewhat subjective and difficult to define in ministry, it was defined in this questionnaire as 'time in which you could be called without prior notice, outside your usual expected work hours'. This may differ from secular roles where on call hours are defined as actual work undertaken (ACAS, 2023). Being on call, whether engaged in actual tasks or simply being available, may however, be damaging to health. Being always available (even if not engaged in work) has been shown to lead to undesirable neurochemical outputs, agitation, low energy levels, altered sense of control, detachment, and affected recovery ability (Dettmers et al., 2016).

3.6.9.2 Work related rumination.

Work related rumination was gauged using the WRRQ (Cropley et al., 2012). As discussed in 3.6.3, for the purposes of this analysis, affective rumination and problem-solving rumination only were used due to the low Cronbach's alpha coefficient in the detachment domain.

Rumination scores can be observed in Table 20. The mean affective rumination score for this group was 16.2 (SD 5.3) which sits in the medium rumination range (Cropley, 2015). Similarly, problem-solving rumination was 17.2 (SD 3.0) which again sits in the medium ruminator range (Cropley, 2015). This study showed 47 (85%) experienced medium or high levels of affective rumination, where thoughts of work provoke negative mental reactions. Additionally, 54 (98%) experienced problem-solving rumination where thoughts of work and work-related activities invade leisure time. Problem-solving rumination, however, is not necessarily perceived as a negative state. Often those who engage in thinking through work challenges outside of work tend to enjoy their roles and do not ordinarily see this type of thinking as negative (Cropley, 2015). As with all work however, it is necessary to have suitable breaks and uninterrupted downtime (Cropley, 2015). This group, therefore, may be at risk of prioritising work activities over mental boundary setting and detaching, which are important self-care elements.

Conversely affective rumination is linked with several health issues including sleep disturbances and fatigue, exhaustion, cognitive issues, mental ill-health, and compromised immunity (Cropley, 2015; Cropley et al., 2016; Firoozabadi, 2018; Querstret & Cropley, 2012; Watkins, 2008). This may be observed in some of this cohort's health facet assessment scores. Notably, 41 (75%) participants met or exceeded the threshold for exhaustion (see OLBI scores in section 3.6.11.3) and the mean cohort SWEMWBS score was lower than the national average (21.7, *SD* 3.5). Additionally, the mean BNSQ score showed similar results to that of workers experiencing work related stress symptoms (Dalgaard et al., 2014). This indicates that some of this group's work-related thought patterns may be potentially harmful

to other areas of their health and wellbeing e.g., exhibiting dysregulated sleep symptoms.

Table 20
Rumination Scores

Categories	*n* (%)
Low affective rumination	8 (15)
Medium affective rumination	33 (60)
High affective rumination	14 (25)
Low problem-solving rumination	1 (<5%)
Medium problem-solving rumination	43 (78)
High problem-solving rumination	11 (20)

Note. Percentages have been rounded to the nearest whole number.

3.6.9.3 Burnout.

Burnout was measured using the OLBI, scores can be observed in Table 21. This measure is scored by calculating the mean score for the items relating to exhaustion and disengagement with the suggested thresholds of ≥2.1 for disengagement and ≥2.25 for exhaustion (Peterson et al., 2008). In the current study the mean score for disengagement was 2.16 (*SD* = 0.48) and exhaustion 2.51 (*SD* = 0.52). Forty-one (75%) participants met or exceeded the threshold for exhaustion and 32 (58%) met or exceeded the threshold for disengagement, suggesting high levels of both in this cohort. Taken together, scores in these domains are indicative of the following (Peterson et al., 2008, p. 87):

Table 21
OLBI Scores

Categories	*n* (%)
Non-burnout - Low exhaustion and low disengagement	9 (16)
Disengaged - Low exhaustion and high disengagement	5 (9)
Exhausted - High exhaustions and low disengagement	14 (26)
Burnt-out - High exhaustion and high disengagement	27 (49)

Note. Percentages have been rounded to the nearest whole number.

These scores suggest that 27 (49%) of this cohort are burnt-out (experiencing high levels of both disengagement and exhaustion) indicative of a job demands-resources imbalance. Peterson et al. (2008, p. 91) suggest those with similar high OLBI sub-section scores may be at risk of health impairment including associated mental ill health, musculoskeletal complaints, sleep disturbances, and cognitive impairment. Additionally, in a study of therapists, high OLBI sub-section scores were associated with poor job satisfaction and negative patient outcomes (Delgadillo, 2018). This is notable when considering the role of clergy and their potential impact on local communities and those who may be struggling or in crisis. Further research is required to determine if this is a concern limited to this cohort or the wider Baptist clergy population.

3.6.10 Importance of Self-care and Permission to Act

Despite some of the health and wellbeing concerns highlighted in this study, 27 (49%) felt they were always supported in their self-care pursuits by their church leadership, and 21 (38%) felt this support from their congregations. However, 10 (18%) participants highlighted they were only supported to self-care on rare occasions by their church leadership, and 14 (26%) on rare occasions by their congregants (Table 22).

Managerial support and encouragement are known to be drivers for employee self-care practices (Horstmann, 2018; Lemmons & Zanskas, 2019). Although clergy do not have a traditional management structure, support from their leadership teams and congregations may assist in self-care strategies, and the lack of perceived support in this cohort may be a barrier to healthful behaviours. This was observed in Proeschold-Bell et al.'s (2011) work, where clergy reported that the support they receive from their denominational hierarchy and congregations affects self-care action.

Table 22
Permission and Support for Self-care

Do you feel you have 'permission' and are supported to take time out to care for your physical and mental health needs by:	Your church leadership *N* (%)	Your church congregation *N* (%)
Yes always	27 (49)	21 (38)
Yes sometimes	17 (31)	20 (36)
Only on rare occasions	10 (18)	14 (26)
No never	1 (<5%)	0 (0)

Note. Percentages have been rounded to the nearest whole number.

The final item in this study briefly highlights a knowledge gap in some participants regarding the importance and interrelationship of the holistic health facets (Table 23). Positively, even if not reflected in action, 44 (80%) of clergy in this study agreed that self-care of other health facets was an important factor for ministry. Yet, 11 (20%) still felt physical and mental care was a less important factor for ministry.

As discussed in Chapter one, there remains among some Christians a critical misunderstanding of the place and purpose of holistic self-care, with the results of this study indicating a similar perception amongst some participants. An argument could be made, therefore, for investment in this knowledge development from multilevel support agencies. Improved self-care practices, as previously discussed, may improve health, both personal and occupational, and by extension the quality and provision of care and evidenced based wellbeing advice to congregations.

Table 23
Importance of Caring for Health

Do you feel caring for your physical and mental health is an important factor for ministry?	*N* (%)
Yes definitely	44 (80)
Yes, but not as important as my spiritual health	6 (11)
Not really, only when I have time, energy etc.	5 (9)
Not at all important	0 (0)

Note. Percentages have been rounded to the nearest whole number.

3.7 Discussion

This study was conducted as a response to the current deficit in UK Baptist clergy health and wellbeing research as identified in Chapter two. This current study sought to quantitatively explore and profile the holistic health and wellbeing of UK Baptist clergy. Data was collected in select health and wellbeing facets in view of comparing these findings to similar adult population data, highlighting if these clergy experience similar occupationally related health inequalities as their international counterparts.

The research questions addressed by this investigation were:

1. What is the holistic (spiritual, mental, physical, social, financial, and occupational) health and wellbeing profile of UK Baptist clergy?

2. How does the sample's health and wellbeing profile compare to the extant trans-denominational Christian clergy literature and general UK adult populations?

3.7.1 Observations from this Study

It is evident from the data collected in this study that the health and wellbeing of Baptist clergy in this cohort is impaired in some facets against comparative adult population data. Table 24 provides a summary of the study's key findings relating to each facet.

Table 24
Key Findings

Health facet	Finding
Spiritual health	• The SHALOM measure appeared to be misunderstood by some participants, where some participants rated their ideal health with a lower score than their current lived experience, giving an overall impossible negative outcome. After partial listwise deletion of seven participants, some still self-rated their spiritual health as poor, fair, or good with only a small difference (≤10) between their ideal and lived scores. Similarly, 12 participants who had a large difference (≥20) self-rated their health as very good, good, or fair. This indicates that despite using the same wording as directed in Fisher's (2010) original measure, the understanding of this measure was generally poor in the context of this cohort. Results of this measure, therefore, are interpreted with caution. • The average dissonance between ideal and lived experience was 15.4. This is significantly higher than other high-pressure roles. • Fourteen (26%) participants self-rated their spiritual health as poor or fair. • Fourteen (26%) rated their spiritual health as ≥very good. • Spiritual health appears to be varied in this cohort, some experiencing low levels and some higher levels.
Mental health	• The mean cohort SWEMWBS score was 21.7 (SD 3.5) this falls below the national adult average. • Sixteen (29%) participants sat below the low wellbeing threshold, only three (5%) sat in the high wellbeing range. • Twenty-four (44%) participants in this study self-rated their mental health as poor or fair. • Thirty-one (56%) rated their mental health as good, very good, or excellent.

- Cumulatively these scores indicate that a substantial proportion of participants may be experiencing low mental wellbeing / health.
- Despite the clear lower levels of mental wellbeing in some participants, 38 (69%) stated they did not have any access to psychological support in relation to their role.

Physical health

- Nine (16%) stated they experienced hypertension higher than national adult data.
- BMI - 16 (29%) of participants sat in the normal weight range, 39 (71%) were ≥overweight. The mean BMI was 28.3, which is higher than the national average
- Nutritional intake was varied in this cohort. Despite the known risks of animal product rich diets, 39 (71%) stated they consumed an unrestricted diet. Thirty-eight (69%) stated they agreed (strongly or somewhat) with the statements around having an adequate knowledge of essential macro and micronutrients. These data suggest a nutritional knowledge gap in some participants. Notably, 30 (55%) of this cohort were seeming to meet the five a day guidelines, higher than the national average.
- Only 10 (18%) participants stated they engaged in the recommended ≥150-minutes per week of moderate intensity exercise. Additionally, 34 (62%) stated they did not engage in any strengthening exercises. This suggests only a small proportion of this cohort are meeting the recommended weekly physical activity guidelines.
- BNSQ-short sleep scores in the cohort appeared high at 14.4, indicative of sleep dysregulation when compared to other international sleep research and studies that have used the BNSQ-short.
- Over half of this cohort self-rated their health as fair or poor. These data suggest poorer levels of self-rated physical health compared to national averages.

Social health

- This study's data regarding social health suggests that these clergy experience poorer social health than the UK adult population. No participants stated they met socially daily, and only 17 (31%) clergy stated they met socially with friends ≥once a week, which is substantially lower than UK adult data.

Financial health	• The number of clergy in this study with a second job was 7% higher than the UK national average. Additionally, the number of clergy in this study who stated they had difficulty making ends meet was 10% higher than the UK adult population. These figures are indicative of financial difficulty in some participants.
Occupational health	• Forty percent of clergy in this study report working 51 hours or more (16% ≥ 61 hours) weekly. This is substantially higher than the national average weekly working hours. Sixty-six percent of those with contracted hours reported being on call for ≥51 hours or more. These levels of working and on call hours are shown to be significantly harmful to health. • Forty-seven (85%) experienced medium or high levels of potentially harmful affective work-related rumination, and 54 (98%) experienced potentially helpful problem-solving rumination. • Forty-one (75%) participants met or exceeded the threshold for exhaustion, and 32 (58%) met or exceeded the threshold for disengagement. Most notably 27 (49%) participants in this cohort sat in the burnout category where both disengagement and exhaustion means were high. These figures are indicative of a job demands-resources imbalance in some participants.
Support to self-care	• Notably, 27 (49%) felt they were always supported in their self-care pursuits by their church leadership and, 21 (38%) by their congregations. This suggests that over half of this cohort do not feel supported to practice self-care activities by their church leadership or their congregations. This type of support is shown to provide a significant motivating factor to self-care in employees.

Note. Percentages have been rounded to the nearest whole number.

3.7.2 Interpretation of Findings

The main findings of this research indicate some health risks and issues in this clergy cohort. Despite the small sample, these results reflect those observed in clergy trans-denominational research as discussed in Chapter two.

In the US where clergy research is more prevalent, very similar health issues and concerns were highlighted:

- Burnout (Darling et al., 2004; Doolittle, 2007; Chandler, 2009) and challenges with poor work life balance and high job demands (Chandler, 2009; Hill et al., 2003; Meek et al., 2003; Rowatt, 2001; Weaver et al., 2002).

Almost half of this study's cohort sat in the burnout category where both exhaustion and disengagement scores were high, this is suggestive of a job demands-resource imbalance.

- Mental wellbeing concerns

  Depression (CREDO Institute, 2006; Doolittle, 2007; Holaday et al., 2001).

  Distress (Weaver et al., 2002).

The mean SWEMWBS score in the current study sat below the national average, and 24 (44%) participants self-rated their mental health as poor or fair.

- Emotional exhaustion (Doolittle, 2007; Holaday et al., 2001).

Forty-one (75%) participants in the current study met or exceeded the threshold for exhaustion.

- Fatigue (Chandler, 2009).

The BNSQ sleep scores in the current study were indicative of sleep dysregulation and subsequent waking and daytime fatigue.

- Obesity, unhealthy eating behaviours (ELCA, 2002; Harmon, 2013; Lindholm et al., 2016; Moore et al., 2017).

The mean BMI in the current study was higher than the national UK average. Additionally, some participants indicated a disconnect between nutritional knowledge and action.

- Social health challenges (Hill et al., 2003; Meek et al., 2003; Rowatt, 2001; Staley et al., 2013; Weaver et al., 2002).

Data from the current study suggests clergy experience lower levels of social health than the UK adult population.

- Spiritual health challenges (Chandler, 2009; Rowatt, 2001).

Despite the challenges in SHALOM interpretation by some, the mean dissonance in this cohort was higher than other high demand care giving professions. Additionally, 26% of respondents in the current study self-rated their spiritual health as poor or fair, suggesting some spiritual health concerns in some participants.

UK works also observed frequent instances of similar occupational health concerns including job demands, role expectation / personal perception conflict, stress symptoms, and some potential differences in support strategies and focus

across denominations (Berry et al., 2012; Guthrie & Stickley, 2008; Kay, 2000b; Kinman et al., 2011; Rolph & Rolph, 2008). Although not all of these areas were addressed in the current study, the data point toward issues with high demands (where 66% of those with contracted hours reported being on call for ≥51 hours or more) and low support (where over half of this cohort do not feel they have the appropriate support to self-care from their church communities). In addition to the commonalities identified with current research, this study also highlights, in some participants, harmful levels of work-related rumination, disengagement, low levels of leisure time physical activity and potential financial difficulty.

Although inferential testing was not carried out in this investigation, some variable linkages may be observed e.g., nine (16%) participants, in the ≥overweight BMI range cited being diagnosed with hypertension or heart disease. Similarly, 15 (27%) participants who cited their mental health as fair or poor also fell into the burnt-out range. Additionally, 16 (29%) of those who self-rated low mental health also showed sleep dysregulation. These types of potential linkages are suggestive of common systemic health issues in some participants in this cohort, but robust conclusions cannot be drawn due to the sample size. It would be advantageous therefore, to replicate this study with a larger sample to explore meaningful relationships through regression analysis. This may assist in latent class and profile analysis and clustering participants according to health profiles, for example, metabolic syndrome risk.

3.7.3 Directions for Future Research

Due to the small sample size, as discussed in 3.7.2 it would be advantageous to replicate this study to attempt to achieve a sample that may be deemed

representative of the wider Baptist clergy population. Inferential testing may be applied to a larger sample to explore linkages between the variables under investigation. Any correlations may be explored through the lens of the job demands-resources model (Bakker & Demerouti, 2007) which may further unpin policy and practice review.

Due to the nature of this study's design, causality cannot be predicted between variables. However, this study points to the usefulness of future longitudinal, multipoint data collection to examine any linkages between facets e.g., leisure time physical activity and mental wellbeing. This may yield useful data from which to develop wellness campaigns at demanding times of year (e.g., Easter, Christmas etc).

In a larger replication of this study, it would be useful to incorporate common occupational health screening elements to provide data from which specific internal health campaigns could draw (e.g., Proeschold-Bell et al.'s [2017] work). Objective measures (e.g., blood pressure, cholesterol levels, blood glucose testing, urinalysis, and waist measurement etc.) could not be obtained in 2020. However, in future iterations of this study, these measurements may provide a valuable addition to the health profile building of this denomination's clergy. The accurate collection of these data may help support the argument for improved hierarchical clergy health support additionally underpinning positive individual healthcare at relatively low cost. Indeed, Proeschold-Bell et al. (2017) in their profile and intervention, used these types of measurements to gauge progress and detail healthfulness and health risk to their clergy participants.

3.7.4 Strengths and Limitations

The small sample size of this study remains a limitation. Had the study attracted a larger sample, statistical tests would have been applied to explore relationships between variables in order to identify at-risk groups for impaired health. Despite this limitation, the study offers a unique and significant contribution to the current data pool on clergy, and paints a preliminary picture of Baptist clergy health, the first study to do so, to the authors knowledge, in the UK, to date. Additionally, despite the small sample size, it was agreed that enough data and sufficient insight was obtained to inform Study two's qualitative investigation.

Every effort was made to select tools and measures that were appropriate for this cohort, and to capture rich data on select facets of health. That said, despite its wide use and known validity and reliability, it appeared that some participants misunderstood the SHALOM tool. Five participants provided impossible responses, and as such were eliminated. It would be useful to ascertain in future research if these responses were an anomaly limited to this group, or if this tool is unsuitable for this denomination.

As with all voluntary survey-based studies, caution must be taken when drawing conclusions, owing to potential bias in participant responses. Snowball sampling may attract a variety of participants, with some providing positive or negative bias. Although this limitation cannot be completely eliminated, mitigation may be somewhat achieved by repetition with a larger sample in an attempt to obtain the widest variety of Baptist clergy representative responses.

Although results remain restricted, this study's data provide an indication of potential holistic health and wellbeing issues and may act as a springboard for individual churches and overarching organisations e.g., BUGB to begin to explore

the prevalence and impact of these issues amongst the wider Baptist clergy population. The study also provides a rationale for further research, internal health and wellbeing discussion, action, policy review and implementation within the UK Baptist clergy community at a local and national level.

3.7.5 COVID-19 Impact

Due to the commencement of this study being quickly followed by the first UK lockdown in 2020, the data collection period was cut short, and so the cohort sample size was significantly smaller than anticipated. This study aimed to collect data from a volume of clergy that would be representative of the UK Baptist clergy population. The early closure of this study was unavoidable due to the global events of 2020, and the desired sample size was not achieved. Rich data was, however, collected from this cohort, and this pioneering study provides a rationale and starting point from which to build future clergy holistic health studies.

3.8 Conclusion

Questionnaire data was collected on a host of health and wellbeing dimensions from 55 UK Baptist clergy. These data highlighted that respondents' health and wellbeing profile was generally similar or inferior to that observed in clergy from other Christian denominations and the wider adult population. Findings indicate health deficits in this cohort in relation to comparative adult populations including mental wellbeing issues and lack of psychological support, physical health issues including high BMI and sleep dysregulation, and social health concerns including lack of social outlets. Most notably 85% of respondents met the threshold for harmful work related rumination, 75% were occupationally exhausted, 58% were

disengaged, 49% were burnt out, and over half stated they were not supported to self-care by either their church congregation or their leadership.

This study was pioneering in profiling UK Baptist clergy holistic health, it is the first of its kind, to date, and has provided a valuable contribution of new knowledge to clergy health and wellbeing research. Current UK works, as discussed in Chapter two, remain limited in their holistic scope. This is the first UK clergy study of its kind, to date, to examine holistic health and wellbeing using a combination of validated and widely used tools and measures to obtain an in-depth profile. Previous published UK works have predominantly had a narrow focus examining areas such as emotional wellbeing, psychological type profiles, and job satisfaction. This study adds new knowledge as it is the first UK clergy study (other than elements of the unpublished Living Ministry Programme [The Church of England, n.d.-b]) to comprehensively explore holistic health. This study has collected new clergy data on health components such as sleep quality, nutritional status, physical activity including strengthening, psychological supervision opportunities, and perceived permissions to self-care etc. in one questionnaire. Additionally, in relation to the US and wider international literature, this study introduces the use of measures such as SWEMWBS, BNSQ-short, NPAQ- short, and WRRQ in clergy research, a further contribution to the research field.

Due to the comprehensive nature of the investigation, it would be valuable to replicate this study to obtain a larger sample size. This would not only provide more data to add to the limited UK clergy research pool, but would also allow for inferential tests to be applied to explore clergy occupational health through the lens of the job demands-resources model (Bakker & Demerouti, 2007).

This study, despite its limitations, has also provided data from which future investigations, interventions, internal discussions, and health awareness projects can draw. Moreover, in providing a baseline profile of the health and wellbeing of UK Baptist clergy, the findings offer a foundation for the study that follows, in Chapter four, which sought to explore the views of UK Baptist clergy on perceived barriers and facilitators to health and wellbeing. This in turn is a precursor to the development, in Chapter six, of an intervention to support the health and wellbeing of UK Baptist clergy.

Chapter 4: Baptist Church Clergy Self-care: A Qualitative Investigation of Perceived Barriers and Facilitators.

4.1 Introduction

The second phase of investigation builds on the findings of Study one which highlighted specific holistic health concerns faced by some participants which were comparative or inferior to UK adult population data, and clergy health studies. Study one, however, was unable to identify individual drivers of positive and negative health behaviours. Stage two therefore, aimed to map the rich lived experiences of clergy in terms of their subjective barriers and facilitators to positive self-care across health domains. Data collection took place between December 2020 and March 2021. A total of 20 online (Microsoft [MS] Teams) interviews were conducted before pragmatic data saturation was determined. Interviews were recorded, transcribed verbatim, and thematically analysed. Two thematic analyses were conducted (one for barriers and one for facilitators). This study ascertained some distinct self-care barriers (e.g., lack of policy) and facilitators (e.g., support from other clergy groups, mentors, and spiritual directors). Moreover, clergy in this investigation cited complex dynamics with their individual social and spiritual health maintenance in relation to occupational demands. The following chapter details the procedure and results of this qualitative investigation, the first of its kind, to date, in the UK.

4.1.1 Research Question

What are the perceived barriers and facilitators to the holistic (physical, mental, spiritual, and social) self-care practices of UK Baptist clergy?

4.2 Ethical Considerations

4.2.1 Institutional Approval

Ethical approval for this study was granted on the 20th November 2020 by the University of Nottingham, faculty of Medicine and Health Sciences (reference DPAP - 2020 - 1658 - 2) (Appendix P).

4.2.2 Consent

Consent was obtained during booking at the start of the internet mediated demographics questionnaire. Participants could not proceed to book an interview without acknowledging nine standardised consent questions approved by the University of Nottingham, faculty of Medicine and Health Sciences ethics committee. These questions confirmed the participants' age, awareness of where to seek support if they had questions relating to the study, alongside confirming they had read and understood the study outline, procedure, expectations, the voluntary nature of the study, right to withdraw, and that recordings of the interviews would be made, transcribed and anonymised.

4.2.3 Risk of Coercion

To avoid any undue pressure or latent coercion, advertising materials were worded neutrally, in that no standard of health was implied or required to participate, interviews sought individual views and opinions only. Generic flyers (Appendix Q) were designed and distributed via social media and through links with the BUGB. The wording and imagery selected was clear, concise, informal, and non-judgemental. It was made clear in email and social media advertising that participation was voluntary.

4.2.4 Confidentiality and Anonymity

Confidentiality and anonymity were maintained through the interview data collection processes employed and the use of Online Surveys (Online Surveys, n.d.). Participants were made aware at the time of booking that the names and email addresses provided would be used to book the interview only. These person identifiable booking data and demographic data were stored on the secure survey hosting site Online Surveys. After recording, transcription, and anonymisation, it was impossible to link respondents' answers back to their person identifiable data.

Recordings were taken of each interview using the inbuilt function on MS Teams, which after the interview, stores the MP4 recording in a password protected Stream cloud drive. After each interview, the MP3 audio file was extracted and the MP4 files were deleted. The MP3 audio files were auto transcribed using the University of Nottingham's secure Automated Transcription Service (The University of Nottingham, n.d.-a). Once returned, the transcripts were accuracy checked. During this process, any person, church, or location identifiable data was redacted. After this final accuracy check against the original audio, the MP3 files were deleted. All steps in the interview process, including where data was stored, how it was used, and how anonymity was protected, were clearly outlined in the participant information sheet included in the consent section of the demographics questionnaire.

4.2.5 Further Support

Participants were provided with a list of support agencies at the end of the demographics questionnaire. The contact details of agencies including Mind, Crossline, and the NHS website were provided, should participants feel the need to discuss or explore any of the health and wellbeing matters raised in the interview.

4.3 Method

UK Baptist clergy participants were invited to take part in a recorded 30 - 45-minute semi-structured interview hosted on MS Teams. Due to the ongoing impact of COVID-19, online interviews were selected. This did, however, allow for clergy to participate from across the UK at their convenience.

4.3.1 Booking

Participants were invited from a QR-code link in the interview flyer to read the participant information, and if they wished to participate, answer the subsequent consent, demographic, and self-rated health questions. Participants were then asked to submit three convenient dates and times for the interview to take place. The author selected one of these dates and booked the interview via MS Teams. This sent a booking confirmation to the participant and some basic instructions for the interview, (e.g., ensuring they were undisturbed for the duration of the interview, and they had any required comfort items to hand such as spectacles or drinks etc).

4.3.2 Camera Use During the Virtual Interview

Participants were invited to join with their cameras off whilst the interviewer's camera remained on. This method was adopted in an attempt to mimic a traditional face to face conversation without the thumbnail video of themselves being a distraction. The year 2020 saw a sudden surge of hyper-digitalisation, as many meetings adopted distance practices using video conferencing software. Subsequently, the term 'Zoomed-out' rose in popularity as a descriptor of the physical, mental, and emotional strain this 'technostress' elicited (Bullock et al., 2022; Ciaunica et al., 2021; Murgu, 2021). As such, the aforementioned approach

was taken in an attempt to relax participants. Although, turning their camera off may be perceived as a disadvantage, as the interviewer may miss non-verbal cues from the participant, this did not appear to negatively affect communication. Participants appeared to relax in taking this 'camera off' approach, with some occasionally forgetting their cameras were off and pointing to and discussing things in their immediate surroundings such as books and paintings. It is noted that online interviews may not produce the same response as in-person interactions.

4.3.3 Semi-structured Interview Schedule

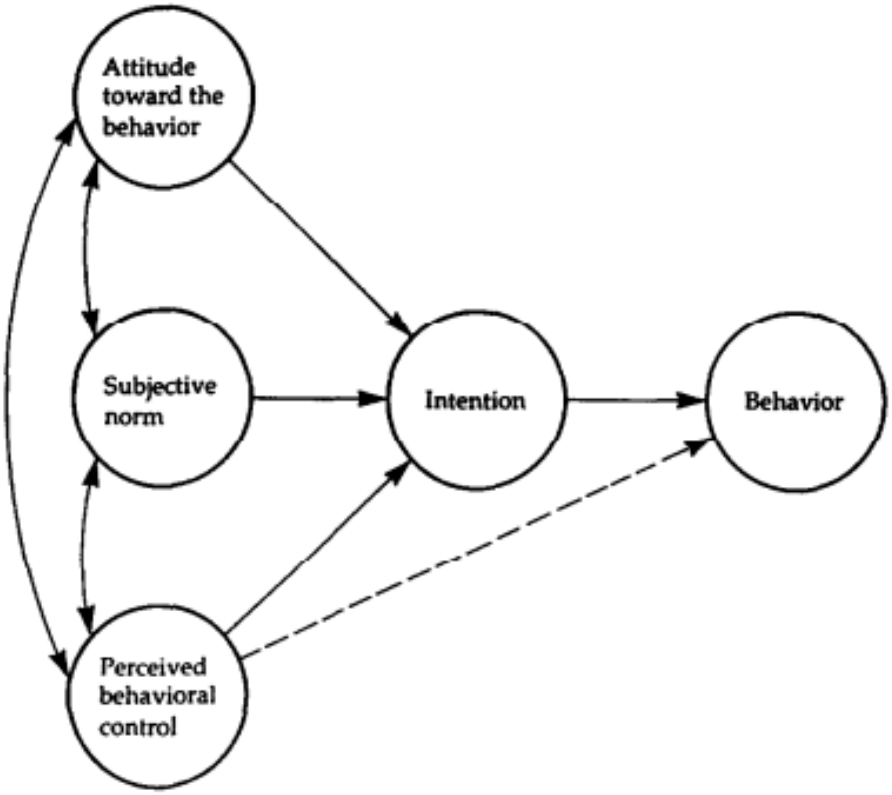
Semi-structured interviews were selected as they allow for the rich exploration of health and wellbeing experiences across select domains, whilst maintaining the flexibility to further discuss pertinent points as guided by the participant. A degree of flexibility was necessary in this study, as there are no UK works, to date, with which to compare. Semi-structured interviews do have some disadvantages, such as greater possibility for the interviewer to influence the data collection through on-the-spot digression, subsequently missing other topics (Coolican, 2006; 2019). That said, the advantages, for the purposes of this study outweighed the disadvantages. The semi-structured approach for example, allows for spontaneity and encourages responsiveness to the participants account, allowing the interview to appear relaxed and informal, much like a 'chat' (Coolican, 2006, p. 87; 2019). This gives space to both the interviewer and participant to respond to thoughts and ideas as they emerge, allowing for a more developed picture of the "participant's unique perspective" (Coolican, 2019, p. 185). This approach aligns with the overarching aim of the study, offering a logical and practicable approach where there are no other UK works with which to compare.

4.3.3.1 Theoretical Underpinning.

Questions were informed by the theory of planned behaviour (Ajzen, 1991; 2012) which posits that behaviours are influenced by attitudes towards the behaviour (behavioural beliefs), perceived social norms (normative beliefs), and perceptions of control over the ability to perform the behaviour (control beliefs), as shown in Figure 2.

Figure 2

The Theory of Planned Behaviour



Note. From "The theory of planned behavior," by I. Ajzen, 1991, *Organizational behavior and human decision processes, 50*(2), p. 182 (https://doi.org/10.1016/0749-5978(91)90020-T). Copyright 1991 by Elsevier Inc.

This theoretical approach was selected as it has proven efficacious for the identification of behavioural barriers and facilitators in other areas of health (Bayley et al., 2009; Eyre et al., 2022; Houdmont et al., 2019; Scannell et al., 2020). Additionally, this theory has been successfully applied to a variety of biopsychosocial behavioural explorations in several thousand studies (Ajzen, n.d.; 2020, p. 316; Bosnjak et al., 2020).

The interview questions sought to explore actions and beliefs around the sub-sections of the Theory of Planned Behaviour. The following prompt questions are examples of the theoretical sub-section application:

- **Attitudes** – What does health mean to you?
- **Subjective norms** – Thinking about your health and wellbeing in general, do you feel being healthy (e.g., looking after your body and mind) is required of a Christian and of a minister?
- **Perceived behavioural control** – What, if anything, hinders or prevents you from looking after your physical health?

The present study acknowledges that human behaviour is influenced by several factors, as broadly encapsulated in the theory of planned behaviour. These influencing factors include the attitudes, perceptions, and social norms within an individual's sphere (Bosnjak et al., 2020). Questions and prompts have been carefully considered to attempt to explore beliefs and actions that may be further tackled in policy and intervention.

4.3.3.2 Overview of the Interview Schedule.

The interview schedule (Appendix I) sought to explore the drivers and barriers to positive self-care across select facets of health (physical, mental, spiritual,

and social) commonly featured within the NHS (NICE, 2019; NHS, 2019). Although these select health facets took a primary focus, the semi-structured interview format allowed participants to discuss any pertinent facets of health they saw fit (e.g., financial health).

The wording of the interview questions and prompts were carefully constructed in view of the common problems of questionnaire wording such as lengthiness, ambiguity, jargon, and leading questions (Oppenheim, 1992). The interview began with a simple introductory question to 'settle' participants "Let's start by having you briefly describe your current role". This was followed by a question which sought to ascertain their individual understanding of health. Following these initial warmup questions participants were then sequentially asked to describe what helps them maintain, and what, if anything, hinders them from looking after their health in each of the selected health domains. Some prompts were included against each question to support discussion where necessary (e.g., "Do you have a health routine, habits, strategy, or plan?"). The penultimate question sought to ascertain their understanding of theological drivers to health, whereby they were asked if they felt looking after their health was required of a Christian and of a minister. This question sought to identify any disconnect between their theological underpinning, perceived norms and their actions and behaviours. The interview concluded by asking participants if they had the opportunity or resources, what area of health would they improve? This question sought to gauge individual ideals of health, and general barriers to their perceived ideal state of health.

4.3.4 Philosophical Underpinning

As qualitative research is about meaning and subjective interpretation of the data from the researcher's unique perspective (Braun & Clarke, 2013, p. 20-21) it is important therefore to state how the researcher observes the world, and how they deduce meaning from experience. It is evident with qualitative research that a truth, will be surmised from the data, however, it is worth noting that another researcher with a different ontological stance may obtain additional truths based on their unique bias and subjective interpretation. This does not dismiss the first researcher's findings, it only adds to the rich exploration of the subject's understanding of their world. Data in this study were examined acknowledging the bias and subjectivity with which the author approaches data analysis.

4.3.4.1 Ontology.

Research design, data interpretation, and ultimate sense making, are influenced by our individual ontological and epistemological stances. Ontology refers to how we as humans determine and make sense of our reality, our separateness or interconnectedness (Braun & Clarke, 2013; Grant & Giddings, 2002). The meanings obtained from an interview are deduced from participant truths. The author approached sense making from this study's interviews by adopting a critical realist approach. This stance perceives truth as something that can be only partially accessed, as the social structures of society influence interaction and meaning deduction of both the participant and researcher (Ballinger, 2004; Braun & Clarke, 2013, p. 27). There is an ultimate truth, however, the interpretation of this truth is influenced by the subjectivity of the individual identifying it. Braun and Clarke (2013, p. 27) summarise this approach in the following example:

> The critical realist position holds that we need to claim that some 'authentic' reality exists to produce knowledge that might 'make a difference' (Stainton Rogers & Stainton Rogers, 1997). For example, we would need to be able to claim that the shame and embarrassment that (some) fat people experience in airline seats (Farrell, 2011) is *real* to produce knowledge that might mean airlines change standard seating sizes. In this position, an external reality (people's feelings of shame) provides a *foundation* for knowledge.

4.3.4.2 Epistemology.

Epistemology refers to the acquisition and classification of knowledge, how a researcher can obtain knowledge and know that it is trustworthy. As with ontology, there are different stances. The author approached this work from the contextualist approach. Like constructionism, this acknowledges multiple truths and realities emerging from the context in which they were observed or obtained (Braun & Clarke, 2013; Jaeger & Rosnow, 1988; McKenna, 2015). Like constructionism, it too adopts various methodologies to ascertain the valid knowledge. It does however, like positivism, suggest a truth, but various routes may be taken to obtain that truth, and that knowledge may be true and valid depending on the context (Braun & Clarke, 2013; McKenna, 2015).

4.3.4.3 Author Stance in Context.

In the context of this study, the author's stance assumes that there is a true meaning of health and healthy behaviours. It is understood, however, that this truth is impacted by both the author's and individual's perceptions, experiences, and personal understanding of healthfulness. For example, a participant may experience a debilitating condition, exercise for 30-minutes twice weekly and deem themselves

healthy. It is understood that their condition impacts their biological functioning and comorbidity risk factors (the overarching truth). However, the context, pain levels, sense of health, achievement and overall wellbeing are true. The author understands that the interpretation of this truth is based on their professional medical knowledge and experience.

Knowledge obtained from the current study is valid under the contextualist stance. Again, using the previous analogy, the knowledge obtained does not fit into a singular reality, healthfulness in relation to physical activity is both true and untrue in this scenario. The feeling of the person being healthy is valid and true knowledge, however, this is only understood when combining the individual context with the author's professional knowledge and experience.

4.3.4.4 Reflexivity.

In addition to the authors ontological and epistemological stances, the personal makeup of the author may influence or inflict bias on the work. Social scientist Krieger (1991, p. 89) describes the impact of the researcher on the data analysis using the analogy of Pueblo native pottery:

> The pot carries its maker's thoughts, feelings, and spirit. To overlook this fact is to miss a crucial truth, whether in clay, story, or science. To ignore the continuity between maker and made is to describe a world of objects where the individual is not seen, where the presence of the artist is not recognized in her work, the presence of a scientist not acknowledged in a study.

Differing from reflection, reflexivity seeks to understand the complex, present, and continual relationship the author has with the data and the participants (Finlay, 2002; Wilkinson, 1988). Providing a clear reflexivity statement on the work

helps readers and future researchers contextualise the work and increases credibility by means of transparency (Dodgson, 2019; Gough & Madill, 2012). In the context of this study therefore, in addition to being a registered nurse, the author is a practicing Christian and has personal links to several Northern Baptist ministers. Four participants were personally known to the author through links to local churches. These participants requested to be interviewed and appeared keen to share their stories. It is acknowledged however, that some information may not have been shared due to the historical relationship dynamic of pastor and congregant. This, however, did not appear to hinder deep personal discussion, with one participant openly discussing their experience of professional burnout and mental ill-health (B12).

The author being a Christian aided discussion, as faith specific terms and practices were easily understood and exchanged with participants (e.g., house group, Christian accountability, worship, and quiet time etc.) in some cases, this aided in doctrinal discussion. A level of objectivity was maintained, however, as although the author was an ‘insider’ to the spiritual life component, they remained an ‘outsider’ with respect to the role of minister. It is known that the concepts of insider and outsider stance may be fluid over the course of the research, and both come with pros and cons (Gough & Madill, 2012; La Gallais, 2008). It is acknowledged, within the present study, that despite the seemingly positive effect of being a Christian insider, analysis may be unintentionally influenced by the author’s faith, their personal experience in churches, and their sub-conscious preconceptions of the role, place, and biopsychosocial expectations of clergy.

Other than those known to the author, no participants disclosed that they knew the professional medical background of the author, this did not appear to

restrict or coerce discussions on health. It is however, acknowledged that being a medical professional may sway discussion, where the interviewee may not want to appear unhealthy to a professional. Sense-making from interview data may also be unintentionally affected, based on the professional experience of the author and previously observed patterns, and consequences, of health behaviours.

Finally, the author's personal health journey and individual makeup may also influence discussion. These factors may include being a female researching a predominantly male profession, being an accented North Easterner, 35 years old at the time of the investigation, and having a history of physical ill-health that has strongly shaped personal health beliefs and behaviours. It is acknowledged that some of these factors may aid or hinder discussion and disclosure.

4.3.5 Analytic Approach

To categorise, analyse, and interpret findings from these interviews, reflexive thematic analysis was selected as the most appropriate approach. Since the seminal Braun and Clarke (2006) paper, "Using thematic analysis in psychology" was published, it has been cited over 165,000 times.

Reflexive thematic analysis offers an "…accessible and theoretically flexible approach to analysing qualitative data" (Braun & Clarke, 2006, p. 77). Reflexive thematic analysis is suggested as a primary analytical method to master, yet the beauty of this robust data analysis framework is that it is not constrained by any philosophical or theoretical underpinning (Braun & Clarke, 2006; 2013; 2019a). In the context of the current study therefore, reflexive thematic analysis was the most appropriate choice, based on the author's level of experience, the flexibility of the approach, and its acceptability amongst the scientific community.

N.B. – The title ‘reflexive thematic analysis’ rather than simply thematic analysis is used here, as it aligns with the author’s evolution of thinking on the method. This title includes the researcher as an integral part of the research and sense making in considering their reflections and reflexivity in relation to the work (Braun et al., 2022). This is of particular importance in relation to generating and defining themes, as opposed to their original phraseology of searching for emergent themes (Braun et al., 2022).

4.3.5.1 Reflexive Thematic Approach.

Thematic analyses were not conducted for the individual health domains investigated (e.g., physical, mental, social etc.) as during stage one, data familiarisation (Braun & Clarke, 2006) it was evident that responses overlapped considerably. Therefore, categorisation followed the approach of Lim et al. (2020) who generated themes across the socioecological model. Notably, this approach mirrors Proeschold-Bell et al.’s (2011) work where themes were instead grouped in the levels intrapersonal, interpersonal, institutional / organisational, community, and societal / policy. Two thematic analyses were therefore carried out within these overarching categories, first for barriers and second for facilitators to positive holistic self-care behaviours.

4.3.5.2 The Six Stages of Reflexive Thematic Analysis.

Reflexive thematic analysis uses six stages to organise and interpret data:

1) Data familiarisation
2) Generating initial codes
3) Generating initial themes
4) Reviewing themes

5) Defining and naming themes
6) Writing the final report

(Braun & Clarke, 2006, p. 87; 2013, p. 202-203; 2019a, p. 593)

4.3.5.3 Stage One - Data Familiarisation.

Interviews were conducted solely by the author. Once complete, the recordings were transcribed using the University of Nottingham's Automated Transcription Service (The University of Nottingham, n.d.-a) and then a manual accuracy check was performed against the original recordings. These steps provided an opportunity for the author to become familiar with the data, begin to observe patterns and common ideas across the dataset, and generate initial notes regarding the observed patterns and commonalities.

N.B. – During the transcription process speech fillers were removed and where necessary, minor wording and grammar was edited for readability. No edits were made to the interviewees chosen vocabulary.

4.3.5.4 Stage Two - Generating Initial Codes.

Although specialist software is frequently used to organise (but not analyse) qualitative data, the author opted to use more simplistic traditional methods for coding. Coloured pens and print outs were deemed more suitable for the author's preferred visual and kinaesthetic learning style. This is the same approach taken by clergy authors Guthrie and Stickley (2008) as discussed in Chapter two. Once this initial coding was complete, the author organised the data into simple Excel spreadsheets for easy navigation.

4.3.5.5 Coding Style.

The current study began with deductive coding driven by the author's understanding of health, the facets of health under investigation, and theory of planned behaviour as a framework. However, upon data familiarisation and the process of generating initial codes, this shifted to inductive and participant driven, as the lack of definitive distinction between the facets became evident. This is not an uncommon approach, examples of this can be seen in the work of Mackenzie et al. (2019) and Sliter and Jones (2016).

4.3.5.6 Stage Three - Generating Initial Themes.

Once the data was coded and collated in to the Excel spread sheet, the data was separated into 13 sheets covering the main categories explored or emergent through the interviews:

1. Breaks
2. Pressure
3. Biblical perceptions of health
4. Lockdown
5. Mental health
6. Physical health
7. Social health
8. Spiritual health
9. Support
10. Policy and supervision
11. Work life balance
12. Theory of planned behaviour

13. Miscellaneous

Each sheet, with its corresponding codes, was then explored for emergent themes across the five categories of the socioecological model:

1. Intrapersonal
2. Interpersonal
3. Institutional / organisational
4. Christian community network
5. Societal / policy

Generated themes across the socioecological model from the 13 broad deductive category's codes can be observed in Table 25. As participants discussed health in an overlapping and interrelated way, and analysis began deductively and transitioned to inductively, in some instances, codes were combined from two or more of the initial 13 categories to generate a theme.

Table 25
Theme Generation Facilitators and Barriers

Socioecological model categories	Initial categories	Barrier or facilitator	Generated theme	Sub-theme
Intrapersonal	Biblical perceptions of health	Facilitator	To serve others, they need to be healthy	
	Lockdown	Facilitator	Lockdown positives	New healthy habits e.g., daily walking
	Miscellaneous, Mental health, Physical health	Facilitator	Exercise promotes good mental health	
	Breaks, Mental health, Miscellaneous, Spiritual health, Support,	Facilitator	Reflection, space away / alone to think	
	Breaks, Miscellaneous, Physical health, Work life balance	Facilitator	Regular annual retreats including quiet days and conferences	
	Miscellaneous, Theory of planned behaviour	Facilitator	Noticeable effects / interrelationships between facets	

	Miscellaneous, Physical health, Theory of planned behaviour	Facilitator	Underlying health issue	
	Spiritual health	Facilitator	Specific supports for spiritual health	1. Liturgy, frameworks, habits, morning routine 2. Doing the job e.g., sermon prep 3. Doing a passive activity e.g., walking
	Lockdown, Mental health	Barrier	Lockdown negatives	1. Low mental health 2. Recreational impacts (days off, holidays, weekly clubs)
	Breaks	Barrier	Poor at taking breaks	
	Miscellaneous, Pressure	Barrier	Self pressure, unrealistic work goals, fear of letting others down	
Interpersonal	Lockdown	Facilitator	Lockdown positives	More intentional about socialising
	Mental health, Support	Facilitator	Family and friends prompt	
	Spiritual health	Facilitator	Family or staff prayer time	
	Social health, Theory of planned behaviour	Facilitator	Specific social health prompts	1. Friendships in church 2. Friends from university and / or outside of church 3. Has Christian friends 4. Uses hobbies to meet people 5. Prefers non-Christian friends
	Lockdown	Barrier	Lockdown negatives	Missing informal social interactions e.g., football, jive class

	Social health	Barrier	Don’t always see closest friends. Try to maintain relationships from a distance	
Institutional / organisational	Biblical perceptions of health, Miscellaneous	Facilitator	Being healthy is a requirement of a minister and a Christian	Want to follow the example of Christ and other biblical figures
	Lockdown	Facilitator	Lockdown positives	Shorter day, increased time, pre-recorded services
	Mental health	Facilitator	Access to the counselling service, awareness, current or past use	
	Miscellaneous, Support, Policy and supervision	Facilitator	Support / peer relationships	Mentoring Church team Peer supervision Spiritual director Regional and BUGB support
	Lockdown	Barrier	Lockdown negatives	Rapid technology skill building and overuse
	Miscellaneous	Barrier	Lack of self-care training at theological college	1. Witnessed colleagues' / graduates' lack of adequate self-care knowledge and skills 2. Received little or no training on self-care at theological college
	Breaks	Barrier	Only one full day off	
	Spiritual health, Work life balance	Barrier	Personal spiritual engagement is restricted / directed by the role	Recognise the need to separate personal and work spirituality
	Work life balance	Barrier	Sometimes the job takes over / no limit to the role	

Christian community network	Support	Facilitator	Support	1. Feels people in the church are supportive 2. Friends doing the same job / someone external to their church 3. Congregation encourages time off
	Spiritual health,	Facilitator	Preach, music, podcast, author	
	Breaks, Spiritual health	Facilitator	Northumbria community	
	Social health	Barrier	Don’t have friends at church	Work and friendships blur and can have negative consequences
	Miscellaneous, Support	Barrier	Role pressures from congregation	A few support, most don’t
Societal / policy	Miscellaneous, Physical health	Facilitator	Health understanding	1. Being able to do what they want to 2. Holism / balance / Jewish Shalom
	Policy and supervision	Facilitator	A form of appraisal, review, check in	
	Policy and supervision	Barrier	No health and wellbeing policy	

4.3.5.7 Stage Four and Five - Reviewing Themes and Defining and Naming Themes.

Once an initial set of themes was generated for barriers and facilitators across the five categories, a process of review and refinement was conducted. It is known in thematic analysis that there is no set frequency of instances that a code must occur to be included in the analysis as a theme (Braun & Clarke, 2006) as such, an objective approach was taken in this study. As the overarching aim of this thesis was to produce real world recommendations, themes were included that were deemed an important issue to raise for individual or wider corporate health, and that may be tackled through inventions and policy changes. This approach is deemed appropriate as per Braun and Clarke (2006, p. 82) who highlight the importance of the researcher's judgement in theme determination.

Although Braun and Clarke (2019b) argue against the use of numerical cut off points, in the context of this study during stages one and two it was evident that codes at three occurrences either did not produce fully developed themes, or the themes could be combined with others to produce stronger themes. Therefore, a general cut off for this study was four or more occurrences to produce a fully defined theme. Following this procedure, the final themes were defined and named.

These first five steps were carried out by the author, then a reliability check and clarification of the final themes were carried out by the author and their supervisor. Where further verbal explanation of the theme titles was required, theme names were adjusted to ensure they were concise, yet clearly described the theme. The final themes across the two thematic analyses can be viewed in Section 4.4.

4.3.5.8 Stage Six - Writing the Final Report.

The results of this study are presented in Section 4.4 onwards. These results provide an evidence base to inform Study four of this thesis, alongside real-world practice recommendations.

4.3.5.9 Pragmatic Data Saturation, Sample Size.

A pragmatic approach was taken to ending data collection. Twenty interviews were conducted, at this point two factors were considered prior to ceasing data collection, pragmatic data saturation, and the practical answering of the research question. This approach is supported by Braun and Clarke (2019b) in reflexive thematic analysis.

4.3.5.10 Participant Name Number Substitution.

For the purposes of differentiation between participants, participant numbers are used to denote authorship against all quotes. This study did not use pseudonyms, as these may inadvertently suggest personal or identifiable characteristics such as gender (Johnston et al., 2023).

4.3.5.11 Rigour.

Rigour in this study was assessed using elements from Ballinger's (2004, p. 542) and Whittemore et al.'s (2001) overviews of qualitative rigour and "trustworthiness" evolution, and Tracy's (2010, p. 840) "Big-Tent" criteria. These criteria seek to promote reflection in research, from across the ontological spectrum by exploring the credibility of research from perspectives such as consistency, triangulation, and confirmability. The criteria researchers use to reflect on their rigour differ slightly across the literature (Henare et al., 2003; Lincoln & Guba,

1985, p. 290; Mays & Pope, 2000; Tracy, 2010). Although these approaches are criticised by some (Smith & McGannon, 2017) a prominent feature across the approaches is researcher reflection and some degree of credibility check. For the purposes of this study therefore, the author carried out the following:

1) Data triangulation – Due to the nature of the semi-structured interviews, if a theme was raised by a participant in relation to a schedule question, it was further explored in subsequent interviews with different participants. This proved particularly useful in this study when exploring the complex facets of personal spiritual engagement and social health.
2) Reflexivity and philosophical underpinning - The author spent significant time considering their personal impact on the research. It is clearly noted that another researcher may have extracted additional truths / codes / themes from the interviews.
3) Personal reflection – Following each interview the author spent time reflecting on the process, line of questioning, emergent topics, and their potential personal impact on the interaction. These critical reflections helped guide data analysis discussions with the author's supervisor and critical friends.
4) Confirmation – Throughout the process, after interviews, generating initial codes, and defining themes etc. anonymised extracts, themes, and topics were discussed with the author's supervisor and critical friends. These discussions sought to minimise author bias, clarify and confirm ideas, themes, and emergent pertinent factors in relation to the research question.

This selective, reflective, and pragmatic approach to rigour analysis is supported by the literature. Maxwell (1992, p. 284) states: “Validity is not an inherent property of a particular method, but pertains to the data, accounts, or conclusions reached by using that method in a particular context for a particular purpose”.

4.4 Results

All participants engaged fully in the interviews answering or expanding on all questions / question prompts. Interviews lasted between 45-minutes and one hour. Participants appeared keen to use the full allotment or give more time for example participant B17 stated, “Sorry I realise that your time has gone, but for instance in church…”

4.4.1 Demographics and Sample Characteristics

Over the course of four months, 20 participants (16 male and four female) were interviewed providing insights into their holistic self-care barriers and facilitators. Although in some circumstances, the data provided by females may differ from that of males, in this study no obvious differences were presented in their accounts. The smaller number of females, therefore, did not appear to impact the results and generated themes in this study. Of those interviewed, 16 were aged $\geq$50 and 18 were married. Participants were predominantly main ministers, and 13 interviewees had $\geq$11 years of experience. Participant sociodemographic and occupational characteristics data can be observed in Tables 26 and 27.

Table 26
Participant Sociodemographic Characteristics

	N (%)
Gender	
Male	16 (80)
Female	4 (20)
Age	
≤29	1 (5)
30-39	2 (10)
40-49	1 (5)
50-59	10 (50)
60-69	6 (30)
Marital status	
Single	1 (5)
Married	18 (90)
Divorced	1 (5)

Note. Percentages have been rounded to the nearest whole number.

Table 27
Participant Occupational Characteristics

	N (%)
Role	
Main minister (e.g., senior pastor)	16 (80)
Co-minister (e.g., associate pastor)	1 (5)
Youth pastor / leader	2 (10)
Other:	
Regional minister	1 (5)
Years of experience	
≤5	3 (15)
6-10	4 (20)
11-20	7 (35)
21-30	4 (20)
31-40	2 (10)

Note. Percentages have been rounded to the nearest whole number.

4.4.2 Self-rated Health

The self-rated health in this group was generally good, results can be observed in Table 28. Most rated their health across the four domains of spiritual, mental, physical, and social as ‘good’ or ‘excellent’. Notably, eight participants self-rated their mental health as fair, and seven rated their social health as fair. Caution must be taken when interpreting these results however, due to the historical period in which the interviews were conducted (i.e., during, or recently emerging from, the UK COVID-19 lockdown).

Table 28
Self-rated Health

Measure	Very poor	Poor	Fair	Good	Excellent
			N (%)		
Spiritual health	0	0	2 (10)	17 (85)	1 (5)
Mental health	0	0	8 (40)	10 (50)	2 (10)
Physical health	0	0	1 (5)	15 (75)	4 (20)
Social health	0	0	7 (35)	12 (60)	1 (5)

Note. Percentages have been rounded to the nearest whole number.

4.4.3 Generated Themes

Figures three to seven represent the generated themes obtained from the 20 interviews. Figures three, four and five pertain to the facilitators for positive self-care practices, and Figures six and seven present the cohort's cited barriers to positive self-care behaviours.

The following number of themes and sub-themes were generated for self-care facilitators:

- Intrapersonal – eight themes (four sub-themes)
- Christian community network – four themes (two sub-themes)
- Social / policy – two themes (two sub-themes)
- Interpersonal – five themes (three sub-themes)
- Institutional / organisational – five themes (six sub-themes)

The following number of themes and sub-themes were generated for self-care barriers:

- Intrapersonal – three themes (two sub-themes)
- Christian community network – three themes (three sub-themes)
- Social / policy - one theme
- Interpersonal – two themes (one sub-theme)
- Institutional / organisational – five themes (two sub-themes)

It is acknowledged that a degree of subjectivity was exercised when categorising the themes under the socioecological headings. A different author may categorise the themes differently, for example, placing items such as biblical prompts in to the intrapersonal or interpersonal category. Despite the author's chosen categorisation, this does not detract from the content of the participants' responses.

4.5 Facilitators to Positive Holistic Self-care Engagement

The following five subsections describe the responses of participants relating to the facilitators for holistic self-care in the intrapersonal, Christian, community network, societal /policy, interpersonal, institutional / organisational categories (Figures three, four, and five).

Figure 3

Themes and Sub-themes Across the Intrapersonal Category that Facilitate Positive Holistic Self-care

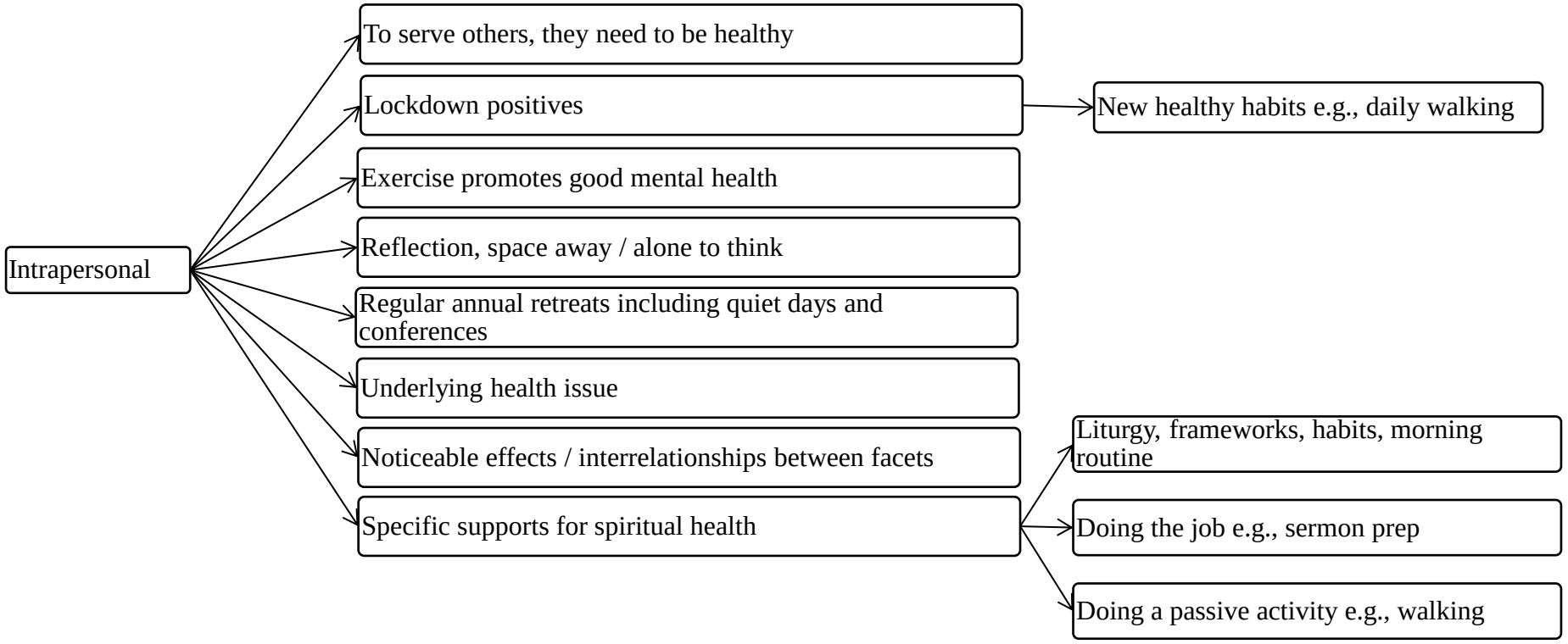


Figure 4

Themes and Sub-themes Across the Christian Community Network and Societal / Policy Categories that Facilitate Positive Holistic Self-care

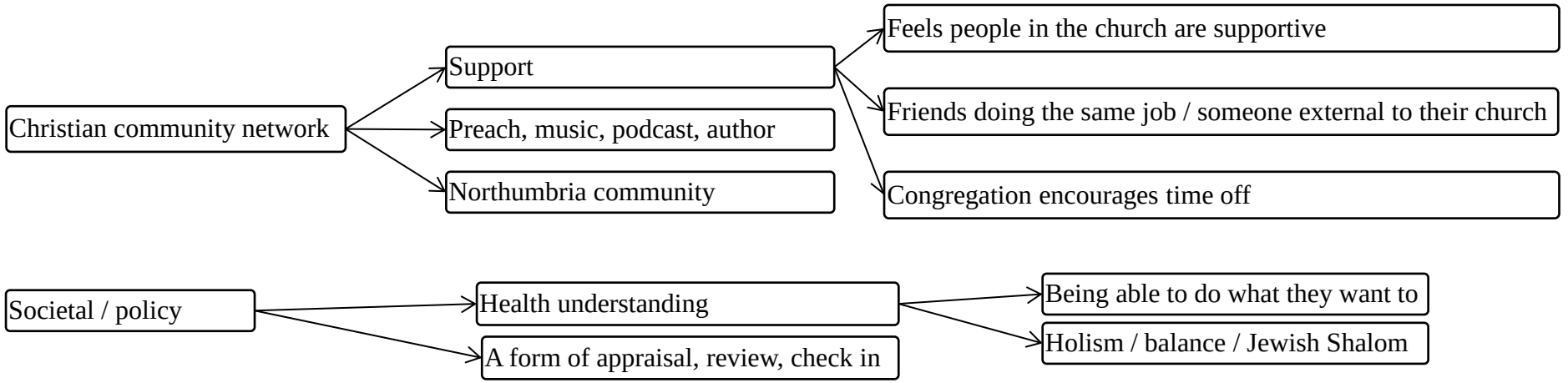
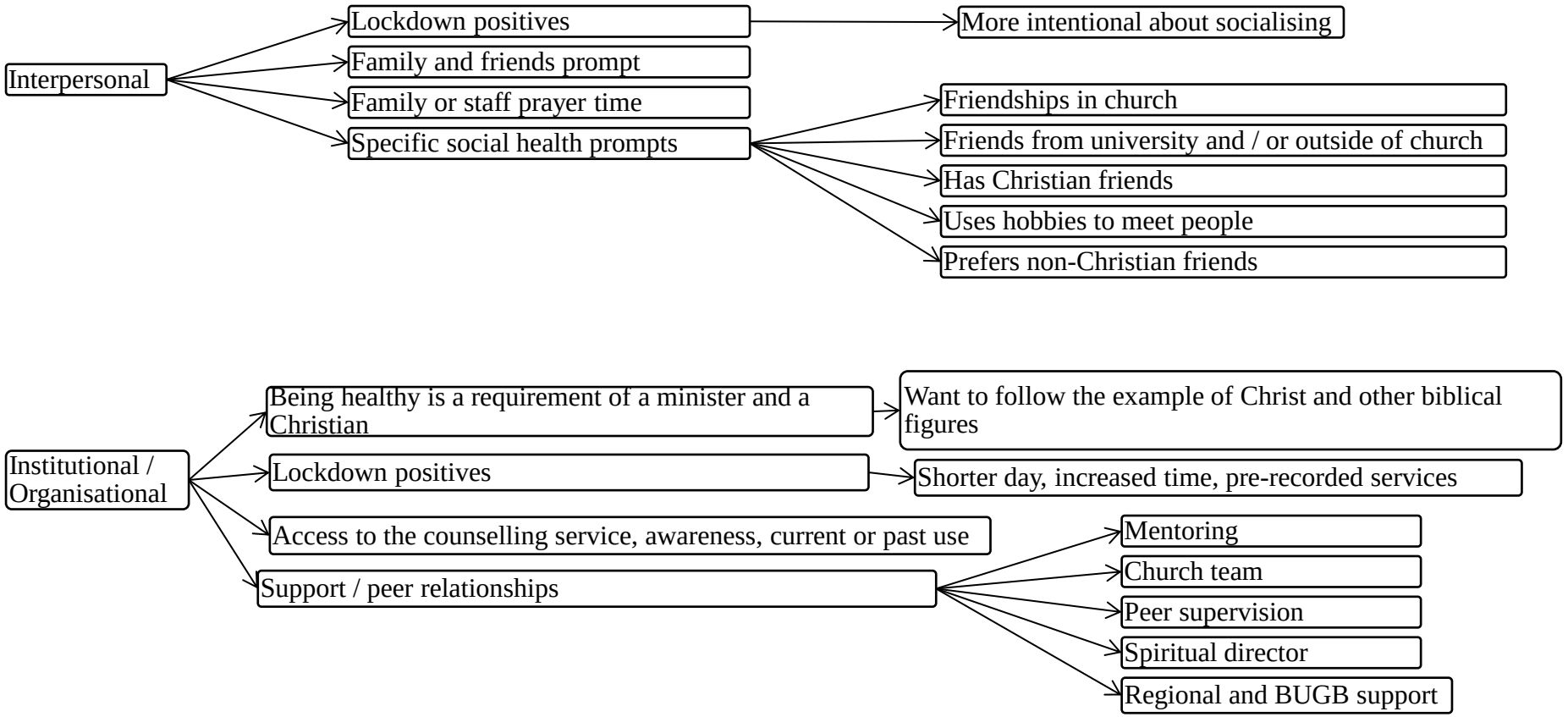


Figure 5

Themes and Sub-themes Across the Interpersonal and Institutional / Organisational Categories that Facilitate Positive Holistic Self-care



4.5.1 Intrapersonal

This category included themes which related solely to the individual participant's ideas, practices, experiences, values, and beliefs not prompted by external factors. This category comprised eight themes:

4.5.1.1 Theme One.

Title - To Serve Others, They Need to be Healthy

Clergy described the importance of self-care across various domains of health as a foundation to serve others within their churches and wider communities, not just for personal benefit.

B24 - *So we have to love ourselves first. If we don't love ourselves first, we've got no chance of loving somebody else … It's not being selfish but making sure you're well so that you can actually do the work that God's given you to do.*

B5 - *I think those things are essential as a minister to be able to serve the Church. And as a Christian I would argue it's even more essential because if we want to share the love of God to the community around us, we have to be, healthy and well ourselves.*

These quotes highlight the vocational nature of ministry, and that participants feel they have been tasked with specific work by God. In order to do a good job as a minister, or more generally as a Christian, they must first ensure they are healthy and able to execute the task at hand.

4.5.1.2 Theme Two.

Title - Lockdown Positives

Sub-theme - New healthy habits e.g., daily walking.

Participants openly discussed a variety of factors pertaining to the UK COVID-19 lockdown which either facilitated self-care or negatively impacted their health and wellbeing. This current theme and sub-theme highlighted the opportunity clergy had to undertake new healthy habits for their personal wellbeing during this period of public restriction.

B24 – *I've taken up running in lockdown … I walk the dogs as well.*

B4 - *…the lockdowns and restrictions have been helpful in that they have meant I've developed a habit of walking a bit every day.*

4.5.1.3 Theme Three.

Title - Exercise Promotes Good Mental Health

Clergy cited the noticeable effects of physical activity on their mental health and wellbeing. They personally observed positive emotional effects from physical actions that prompted them to maintain the activity.

B18 - *A good game of squash puts a lot of things into perspective.*

B21 - *…every Sunday afternoon I would say I'm going to get my head straight and I would go walking in the* (Location) *typically on my own, maybe with our dog, just to have time alone and for me, that's a big part of my mental health.*

B23 - *Doing the exercise, the running and cycling I guess probably helps my mental health because sometimes it gives me a chance to reflect and think.*

4.5.1.4 Theme Four.

Title - Reflection, Space Away / Alone to Think

Clergy considered the importance of time away or alone to think and reflect. This appeared to be a key factor in maintaining positive mental wellbeing. Several clergy cited these practices in response to periods of personal mental ill-health.

B17 - *And I think with having more time and more space, I've probably dealt with some little issues that have come my way a bit better than I might have done when I was too busy.*

B16 - *I tend to be quite reflective now and that's developed over time and so if there's a problem an emotional problem or a mental problem or a relationship problem, I'll be fairly quick to ask myself right what's going wrong here? What, needs to happen? What needs to change?*

B11 - *And also that quiet time of just, you know 40-minute walk in the morning or something just to be.*

4.5.1.5 Theme Five.

Title - Regular Annual Retreats Including Quiet Days and Conferences

In addition to designated regular time to reflect, clergy cited the benefits of retreats, conferences, and quiet days. This is scheduled time in their working year where they were provided uninterrupted space to focus on God and their relationship with the Creator. Some also use this time to reflect on their ministry, calling and church or community goals. These retreats came in various forms from guided weeks away at centres like the Northumbria Community, or uninterrupted self-guided personal time using aids like spiritual labyrinths.

B4 - *…in the past I've been to a thing called the Northumbria Community a few times. Done some guided retreats there and found those immensely helpful.*

B6 - *Retreats tend to be much more about my walk with God than actually my ministry.*

B27 – *I'm a great believer in retreat. Great believer in silence, you know, and I just love that whole aspect of reflection.*

4.5.1.6 Theme Six.

Title - Underlying Health Issue

Several participants disclosed underlying health issues. These issues were discussed as a driver for participants to maintain self-care strategies to support their overall health, and to prevent exacerbation of their conditions or deterioration of their overall quality of life.

B18 - *I have high blood pressure, I've had it for a dozen years, so I take tablets for that, that's why I've been conscious of watching my weight and always wanted to play squash better…*

B2 - *A few years ago I had problems with my heart which resulted in getting a stent fitted in one of my arteries. So that's affected my health and how I try to do my job actually and how I try to cope with stress and diet so that's an ongoing thing for me now … I can't do as much as I used to do so I try and work smarter.*

4.5.1.7 Theme Seven.

Title - Notable Effects / Interrelationships Between Facets

A driver for many participants to maintain self-care strategies was the noticeable effects of one activity on another area of their health. Participants were acutely aware of the interrelationship between some health facets through their own experiences of positive or negative health and their responses e.g., "And for myself, in a ministry post you need to do exercise to keep your sense of wellbeing" (B19). Some cited specific effects on their mental or physical health e.g., "I try my best not to use a phone or a computer or what have you in the last sort of two hours before bed. And if I do for whatever reason, I do struggle to sleep" (B23). Or a simple

visual stimulus e.g., “But what I have found is that if I’ve walked, my weight goes down a bit” (B4).

Some described the positive effects on areas like mental wellbeing more generally. When discussing dog walking, one participant stated the activity supported their mental health as, “what I describe as keeping my head straight” (B21) another said, “There’s something about walking that helps you process your thoughts” (B2). Another participant discussed exercise generally, “Like obviously it is good for you physically. I think it’s good for me head wise, just gets you out of the house, gets you a bit of fresh air” (B9). Despite not using the accurate medical terminology these participants were likely describing the neurochemical release, oxygenation, increased cerebral blood flow and increased general cerebral functioning during physical activity (Deslandes et al., 2009). They could feel the effects even if they could not accurately articulate why, clearly acknowledging a strong health interrelationship for them individually.

4.5.1.8 Theme Eight.

Title – Specific Supports for Spiritual Health

Sub-themes:

1. Liturgy, frameworks, habits, morning routine.
2. Doing a passive activity (e.g., walking).
3. Doing the job (e.g., sermon prep).

Likely due to their roles, participants cited specific supports for their spiritual wellbeing, appearing keen to discuss these in-depth. Many cited routines, rhythms and habits that support their spiritual wellbeing:

B27 - *I sometimes use liturgy or something like that to help me. Celtic Daily Prayer or … the order of Baptist Ministry have seven days' worth of things to help in prayer.*

B8 - *I try and start each morning with a time of prayer and reflection … just having that moment to centre myself and reflect on scripture and things.*

Notably, several cited the benefits of a passive or mindful activity where they allowed themselves dedicated time to focus on their personal spirituality whilst completing another activity.

B9 - *I quite enjoy washing the dishes to be honest as well … that just gives me half an hour and your head can go to somewhere else. So, you know, sometimes I'll just put on the music or stick on a preach or talk or something while I'm doing that.*

B24 - *If I'm out running I normally run to Rend Collective Experiment* (a lively Christian worship band) *because they're quite bouncy and I actually found that running has become a form of worship.*

Although many discussed negatives of their ministry roles on their personal spirituality (see barriers section) some cited a specific support derived from performing their role.

B20 - *I learn so much from preparing a sermon which obviously I'm delivering to somebody else, but the first person that it's got to be delivered to is me.*

B24 - *I actually really enjoy preparing for sermons because again, it means I can really get into a bit of Bible study, into a real juicy bit of Bible study. And I often find that the person who benefits most from me preparing a sermon is me.*

4.5.2 Christian Community Network

The themes in this category related to the church community, which is the congregation, and the wider community of Christians (nationally and internationally). Traditionally, a community may be perceived as those within a physical locality. In Christian terms, both from a biblical and social perspective, however, community often also includes those within the wider Christian church with whom they interact. This may be through proximity at church, or through music, the arts, podcasts, or online preaches etc. Through these tools believers may gain focus, clarity, comfort, and direction. This is often referred to as the priesthood of all believers and has its theological basis in the life of Paul, who spoke God's word to churches across the middle east through letters (Shaw, 2013; Weaver, n.d.). Due to the example of Paul and adoption in the Baptist denomination of this priesthood, it is widely accepted that God can speak to individuals through this wide network and by various means (Lape, 2021; Lauder, 2023; Petersen, 2022). Therefore, in the context of this category, 'Christian community network' facilitators may be physically close to the minister or derived from the wider national and international Christian community. This category comprised four themes:

4.5.2.1 Theme One.

Title – Support

Sub-themes:

1. Feels people in the church are supportive.
2. Congregation encourages time off.

3. Friends doing the same job / someone external to the church.

Although many clergy felt the congregation did not understand their role and were not supportive of their personal health and wellbeing (see barriers section) some reported positive experiences with their congregations actively supporting their self-care.

B8 - *We are a very compassionate church and so it was actually their instigation that led to the compassionate leave. Because they could see that I was feeling quite weighty upon me, they could see that I looked heavy in my eyes and not really energised.*

B19 - *…they assume the minister would do too much rather than too little, and that the minister should be protected from themselves...*

B24 - *One or two in the congregation will always check in on me. And if I've not had a day off, or if I'm working too hard, I get told off* (laughs) *which is lovely.*

In addition to congregational support, support from friends and those external to the minister's church featured as a common theme amongst this group. Gaining perspective from people outside the situation, and those who understand the role, appeared important.

B5 – *I've got a friend … and we speak extremely regularly on the telephone, and we have a similar background in Churchmanship and in size and style of Church and ministry. That helps greatly because he understands where I'm coming from.*

B12 - *I have two other minister friends who I've known for 25-30 years who we meet on Zoom every month or so and have an hour or so where there's no*

pretention whatsoever. Everyone knows each other, you can't pretend about stuff. That's a really useful sounding board for where I'm up to.

4.5.2.2 Theme Two.

Title – Preach, Music, Podcast, Author

Support for many Christians is found through meditating on Christian publications including, music, writing, and art, carefully incorporating these tools into their daily Chrisitan journey. These tools, in this group, appear to offer a significant support to their personal wellbeing and spiritual health.

B27 - *I do a little bit of Roman Catholic reading with people like Richard Rhor and Henri Nouwen, and that keeps me balanced I would say spiritually.*

B10 – *I like a journal at the end of each day, but very simple journal. So, Ignatian Spirituality, what's brought you life, what's been the opposite of that, … it's expanded, so it's Pete Greig from 24/7.*

4.5.2.3 Theme Three.

Title – Northumbria Community

There are several well used Christian retreats nationally, arguably one of the most well-known and used in the UK is the Northumbria Community. As well as offering a retreat space, this group offers daily meditations, prayer guides, books, and other distance support under the banner of the Celtic tradition (Northumbria Community, 2020). The Celtic tradition is notable in the context of this thesis as they seek a life in balance, promoting holism of self and environment (Miller, n.d.; Smith, 2022). It is notable therefore that the community was well known within this cohort and many participants had some contact with the community, either by their publications or physically visiting the centre.

B5 - *I found the Northumbria Community Office and discipline of saying that everyday, very beneficial.*

B6 - *I think the discipline of a rhythm and routine is definitely a good thing. And that's something that's been encouraged through my walk with the Northumbrian community.*

B27 - *But what really has benefited me beyond anything else and I return to it when I'm in difficulty or I'm stressed, or whatever, is a Celtic way of looking at Christianity.*

4.5.3 Societal / Policy

This category explored themes relating to societal norms and policy (organisational and wider, e.g., national). These factors have not necessarily been developed by the individual but are understood, believed, or adhered to, and govern self-care practices in this group. This category comprises two themes:

4.5.3.1 Theme One.

Title – Health Understanding

Sub-themes:

1. Being able to do what they want to.
2. Holism / balance / Jewish Shalom.

This theme explored the participants understanding of health and wellbeing. What being healthy means to them on an individual level, and their personal basis for health. This theme had two distinct sub-themes. Some clergy felt the basis of health was physical and / or mental ability, being able to achieve their intended daily goals without difficulty:

B4 - *Being able to do whatever one feels one should be doing or wants to do, without a sense of physical or mental issue holding one back.*

B5 - *Physical health basically means I can physically do what I want so I can go walking, which is my big thing. I should be able to put my backpack on and go for an 18 mile walk without feeling it.*

This understanding appears limited, and suggests health or healthfulness is being able to function and do so without pain or difficulty. This suggests little understanding of ill-health, underlying conditions, or protecting against illness and disease.

Conversely, several clergy discussed health in terms of holism, balance and the Jewish tradition of holism, holiness and Shalom:

B12 -…*the Old Testament Jewish idea, they had a very connected understanding theologically of health, which would be much more than just physical health and would be very holistic, so would recognise the impact of physical poor health on our mental health and vice versa. So that very holistic understanding would be my understanding of health.*

B16 - *I look at the Hebrew word Shalom as a good starting point which encompasses the physical, the mental, the social, the spiritual, every part of life and I think for good health, all those need to be encompassed in some way.*

This understanding of health is extremely valuable in approaching the topic of ministerial health improvement. Those that understand holism and balance may be more open to multifaceted health interventions, where those who feel health is functioning without issue may be less inclined to participate in primary prevention.

4.5.3.2 Theme Two.

Title - A Form of Appraisal, Review, Check in

Despite the lack of formal health and wellbeing policy across all interviewed churches, those interviewed cited creative alternative strategies to voice needs and concerns. Many relied on open communication with their teams and informal check-in's. Others cited more formal appraisals and review, using these annual opportunities to discuss concerns and seek support. Although these communication strategies are valuable, and appear to support team cohesion and communication, the beneficial effects of these in addition to formal health and wellbeing policy are unknown.

B12 -…*I think what the team is good at is that the language of care and concern is very readily talked about and expressed. … it's not taboo in the staff team.*

B27 - *I do have an annual appraisal and I always have done. And then in between we meet for more informal meetings, so I find that really, really useful. …it's a time for me to reflect, for them to reflect, for them to feedback to me.*

4.5.4 Interpersonal

This category pertains to themes where the minister interacts with other people or groups, separate from themselves, but where there is a level of interaction. This category comprises four themes.

4.5.4.1 Theme One.

Title – Lockdown Positives

Sub-theme:

- More intentional about socialising.

A specific positive that was born out of the UK COVID-19 lockdown, was the importance of socialising and by extension social healthfulness. The restrictions placed upon the nation, brought into sharp relief the necessity of interaction with others (family and friends). Although clergy appear to have complex social health (see the barriers section) they cited significant effects from the restrictions, prompting them to seek out social opportunities, and recognise their benefits. One participant, with regards to socially distanced walking, said: “I’m gonna keep this up when things ease a bit, it’s not something that I was doing much before and I think, it’s quite therapeutic and it’s a good thing to do in terms of friendships” (B2).

The COVID-19 restrictions meant that in-person contact was extremely limited for prolonged periods of time. As such, a significant proportion of in-person contact (e.g., teaching, church services and work) was transferred online through platforms like Zoom and MS Teams. Notably, many in the public utilised these communication methods for socialising, this was true of this cohort, with one participant summing the benefits as such: “I have done more social calls via Zoom and on Skype and these kind of things with people who actually you think we don’t need to wait every however long before we talk to each other, we can do it much more regularly online … in some ways I’ve felt more socially engaged with some people in the last year then less” (B16).

It would appear from these responses that this seemingly negative period has prompted some in this group to consider positive health change in the social domain. The sustainability of this type of social engagement, however, is unknown.

4.5.4.2 Theme Two.

Title – Family and Friends Prompt

This theme encompassed behaviours where clergy were prompted to self-care by others within their communities. From simply making sure they received adequate rest e.g., "…she's good at telling me to stop, let's just go out for a walk and that kind of thing…" (B2) to encouraging open dialogue about mental health and wellbeing with peers or the wider church:

B10 - *I suppose I just confide in a lot of people; you know general people; I think that's really helpful.*

B12 - *…we have had services … where we've talked about mental health, we have had various members of congregation talk about their own experiences and that I wanted to normalise that kind of language and talking at* (Church name).

4.5.4.3 Theme Three.

Title - Family or Staff Prayer Time

Clergy cited that sharing their personal spiritual practices, namely prayer, with close colleagues and family formed a significant part of their spiritual wellbeing.

B9 - *…now we try to pray as a family each day. So that's part of our rhythm.*

B11 - *So that whole rhythm of prayer is something that we're acutely aware of the importance of that in our own lives, and of building that now into the daily life of the church.*

This is notable, as these participants appear to be supported spiritually by these prayer times with others. Therefore, encouraging more of these kinds of practices may work towards supporting the sometimes neglected and seemingly complex (see barriers section) personal spiritual health of clergy.

4.5.4.4 Theme Four.

Title – Specific Social Health Prompts

Sub-themes:

1. Friendships in church.
2. Friends from university and / or outside of church.
3. Has Christian friends.
4. Uses hobbies to meet people.
5. Prefers non-Christian friends.

Friendships and social health in ministry appeared complex within this group. The most commonly cited promoters to their individual social health are outlined across the above five sub-themes. Some clergy had strong feelings regarding having friendships with their congregation, and this appeared to split the group, with many citing they did not feel they could be friends with their congregants (see barriers). Some in this group, however, felt as part of their role they needed to be friends with their congregation: "I think it's important to the role, you should have a minister, you deserve a minister who likes you, who you can engage with. So, I have lots of friendships with people in the church across the board" (B12). Some reported the positive effects of friends in the church: "…there are people in the church that I would count as friends and I could guarantee that they would be there for me come what may. And whatever we talked about would never ever go to anyone else. So, I feel kind of pretty blessed in that way" (B21). One participant drawing on their theological basis stated: "I often go back to thinking about where Jesus said to his disciples, I no longer call you servants but call you my friends. I think well, if Jesus called His disciples friends then surely we can have friends in church" (B23).

Several participants cited the importance for them to have friends outside of church, either physically or those who are non-Christian. This may be friends from university, friends at a social group, or other clergy at other churches. Several discussed the personal importance of non-Christian friendships to them, citing the grounding nature of these relationships: "I have friends who know me as (Name), not reverend (Name) or pastor (Name), they know me as (Name). And those relationships are really important because they ground me and remind me that I am just like everybody else" (B20). Another stated: "…my best friend is probably what I'd say non-Christian, non-churched person … we do talk to each other, but I guess I wouldn't talk to him at all about church stuff. I'd talk to him mainly about maybe family stuff just how I am as an individual. We have a very good friendship... I don't have to be on duty at all with him" (B23). This participant summed up the overall comments of the group in their quote: "…having a very close friend that made a difference who was completely outside of the church, just gives you a different perspective on life. Actually, you know there's more to life than church. So, I would see that as vital for any minister, to kind of have friends outside the church…" (B6).

In addition to their non-Christian friends, several participants discussed the benefits of meeting with other Christians and / or local ministers to discuss church matters and gain perspective. This participant simply summed up the benefits in their comment: "I've got mainly Christian friends I've got to say and that's really helpful because when I talk spiritually with them and they with me, we have an understanding of each other" (B27).

Of the health facets explored in this study group, social health in this group, appears the most complex, with clergy requiring a balance of people and influences to support and balance them spiritually and personally.

4.5.5 Institutional / Organisational

This category considered promoters for health that were related to the institutions and organisations to which the clergy belong. These include the Christian church generally, the Baptist denomination, The Baptist Union of Great Britain, regional Baptist associations, individual churches, and theological training colleges. This category has four themes.

4.5.5.1 Theme One.

Title - Being Healthy Is A Requirement of A Minister and A Christian

Sub-theme:

- Want to follow the example of Christ and other biblical figures.

The clergy in this group unanimously cited a requirement to care for their personal health and wellbeing, specifying various biblical imperatives. This participant, for example, shared their perspective and the necessity to also share this message with their congregation: “I preach this regularly to people in my church who are also horrendously bad at looking after themselves … I would say to them, as Christians there’s that bit that Jesus tells us, he says, you know we’ve got to love the Lord our God with all our heart and soul and mind, and we have to love others as we love ourselves. So, we have to love ourselves first. If we don’t love ourselves first, we’ve got no chance of loving somebody else” (B24). Another discussed scriptural examples: “…the fact that God calls us to steward and look after the whole of creation, so as we are part of creation, that’s an important part of that call really. …So, it’s all there in scripture about making sure we are looking after ourselves really. …it’s not just beneficial, but is scriptural” (B6).

Many participants cited passionate rationales for self-care and whole health e.g., B20 – *I'm very, very firmly of the belief that God is interested in the whole person. ...I would argue against the view that God's is only about pie in the sky when we die.* Yet, this participant summed up the general feeling of many in the group, suggesting that the awareness of the commandments on self-care is there, however, there appears a struggle in practical application: "…the greatest commandment, you know love God, love others as you love yourself. That's always been like you just trail off at the end, as you love yourself" (B8).

4.5.5.2 Theme Two.

Title – Lockdown Positives

Sub-theme:

- Shorter day, increased time, pre-recorded services.

Indicative of the known demands on clergy's time, a notable facilitator to self-care within this group was the COVID-19 lockdown mediated shorter working day on a Sunday. This, for some, left more time for the self and family, activities, and increased spiritual wellbeing, through the use of pre-recorded services, or shorter meetings.

B11 - *Interestingly, in the current climate, because we pre-record everything, we've sort of got our Sundays back, which is rather nice.*

B20 - *I have to say that one of the benefits of COVID has been the increased time that we have which I think has been used by Christians to, to draw closer to God.*

B23 - *Sunday afternoon again, rest family time ... at the moment nothing really hinders it and I think that a large degree of that is probably down to the fact*

that we're in a pandemic and there's really not much else to do. So, for me to go off cycling for say three hours on a Saturday morning isn't too bad, whereas I think when we're able to do stuff again to give three hours on a Saturday wouldn't be appropriate or appreciated.

4.5.5.3 Theme Three.

Title – Access to the Counselling Service, Awareness, Current or Past Use.

Several ministers were aware of, or had used, the Churches Ministerial Counselling Service. This service provides free or low-cost counselling support to clergy (and adult family members) from several denominations including the BUGB (Churches Ministerial Counselling Service, n.d.). The availability of this service appeared to significantly support the mental wellbeing of some clergy in this group. One participant spoke about the vital skills they had learned: "I'm now far more kind of self-aware and recognise some of the signs and the stresses and the issues and I've been fine" (B20). Some discussed the awareness of the service and the support it provided in knowing there was someone to reach out to: "You contact your area organiser and say I need some counselling … So, I feel very much supported by the Church, the denomination in that" (B5).

Although available through the BU, no participants cited using pastoral supervision, akin to clinical supervision in other professional caring roles (Baptists Together, 2023).

4.5.5.4 Theme Four.

Title – Support

Sub-themes:

1. Mentoring.

2. Church team.
3. Peer supervision.
4. Spiritual director.
5. Regional and BUGB support.

In addition to the support from the counselling service, ministers spoke at length about support from a range of useful formal peer relationships. All participants had either, or both, a mentor or spiritual director. The role of a mentor is to "…listen to the issues that you bring to them and then ask questions so that you see matters in the round and can identify ways of moving forward" (Baptists Together, 2023, p. 1). A spiritual director stimulates the spiritual health of the individual, assisting reflection and a deepening of their relationship with God, assisting clergy to become more aware of the presence of God, and respond appropriately (Baptists Together, 2023, p. 1). Clergy generally spoke very positively about these relationships e.g., "I have a both … my spiritual director, I guess, keeps me accountable on my spiritual walk, whereas my mentor is simply giving advice and helpful insights and resources to do with the work in ministry" (B6).

Notably, several clergy discussed the benefits of a formal peer supervision relationship. These are formalised regular meetings with other clergy performing the same or similar roles.

B20 - *So, I have good relationships with other ministers in the area and we meet regularly. We have a good moan to one another about what's going on* (laughs). *It's really nice to be able to confide with somebody who is outside your own little congregation, but who is going through similar life experiences.*

General comments pointed toward having and finding these professional relationships useful and necessary to their roles. One participant commented: "I'm

not really that fussed what it looks like as long as people are supported and not isolated. If that's better as peer to peer, then great. If that's better as mentoring or something else, great, as long as people aren't feeling isolated or abandoned in ministry, I don't really mind what their structure of support is" (B9). Overall, this points towards the potential for isolation and requirement for outside support for health in their ministerial roles.

4.6 Barriers to Positive Holistic Self-care Engagement

This second reflexive thematic analysis explored the same previously discussed categories, but for barriers to positive self-care engagement (Figures six and seven). The following describes the responses of participants in these areas. The category descriptors remain the same as the previous facilitator section.

Figure 6

Themes and Sub-themes Across the Intrapersonal, Christian Community Network and Societal Policy Categories that Create Barriers to Positive Holistic Self-care

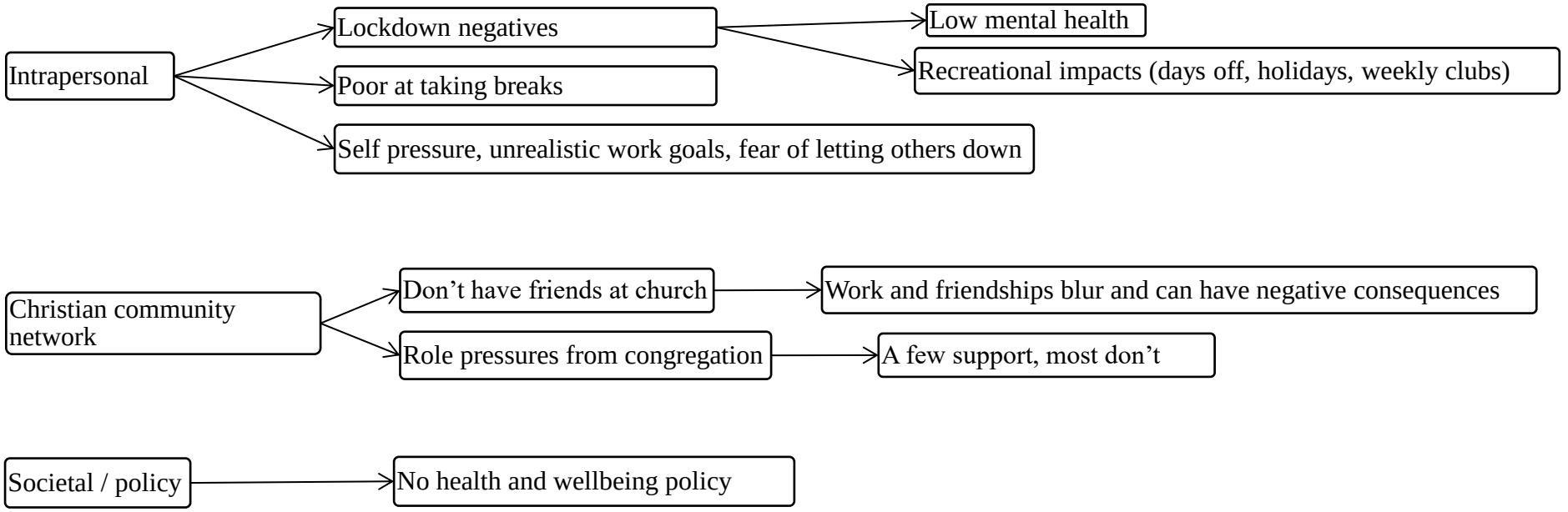
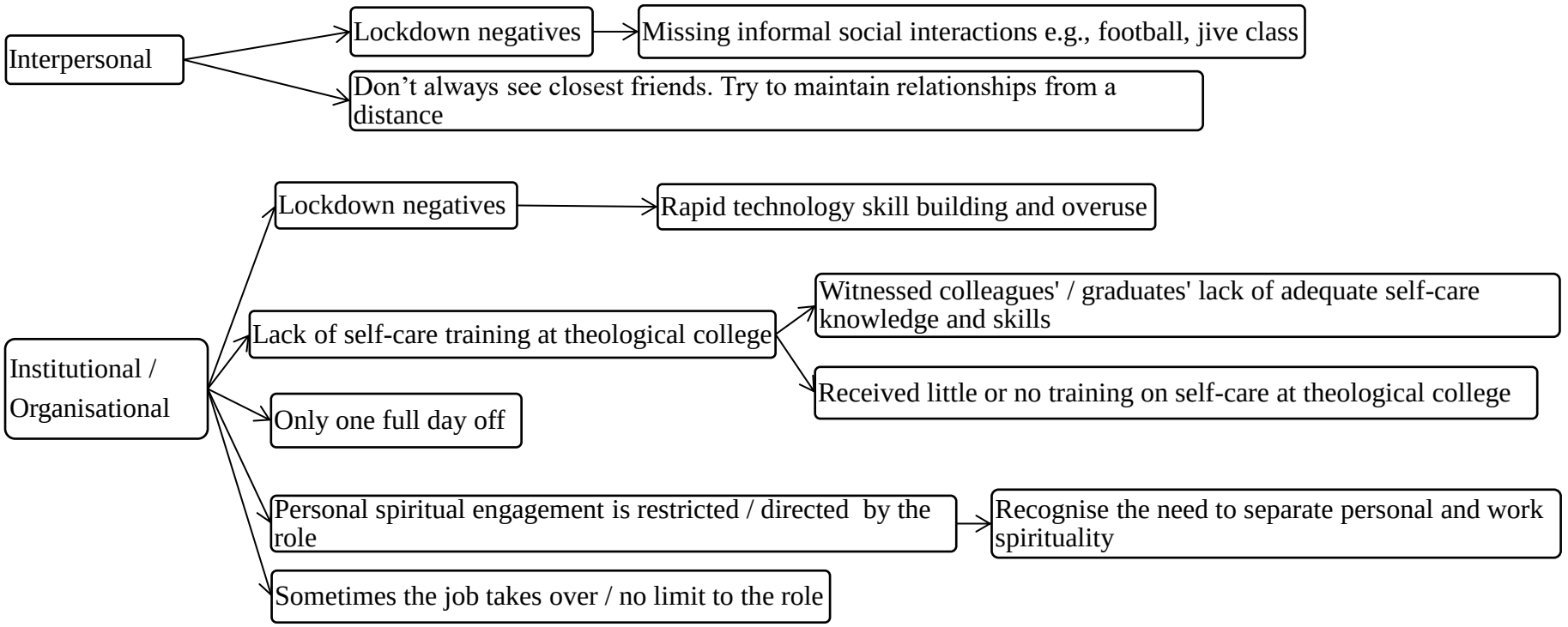


Figure 7

Themes and Sub-themes Across the Interpersonal and Institutional / Organisational Categories that Create Barriers to Positive Holistic Self-care



4.6.1 Intrapersonal

This category explored the barriers to intrapersonal self-care across three themes.

4.6.1.1 Theme One.

Title - Lockdown Negatives

Sub-themes:

1. Low mental health.
2. Recreational impacts (days off, holidays, weekly clubs).

Due to the period in which the interviews were conducted, the impact of the UK COVID-19 restrictions featured heavily as a barrier to positive self-care. As seen in the following theme, clergy in this group cited that they were generally poor at taking breaks, lockdown however, appeared to impact the little time they did engage in recreation by limiting or stopping rest time, holidays, weekly clubs, or even standard days off.

B5 - *This year is the first year in, ever, I haven't had a retreat week.*

B8 - *But then COVID hit, and we had to cancel my sabbatical. So, it meant in terms of health, I was on the fumes, like the tank was empty…*

B19 - *The March to July that was pretty mental to be frank … I worked solid. This was probably 17-hour days. The first fortnight, ensuring, along with others, that people in our church and community were taken care of for food provision all the rest of it … Obviously, every time we booked a holiday or planned time off the restrictions came in … I've not really had proper time off, which is not great really.*

Unsurprisingly, a further effect of these restrictions and lack of adequate rest was poor mental wellbeing.

B10 - …*like lockdown, and that, emotionally wrecks you basically, … and actually, over lockdown and the last year or so, I felt like my mental health hasn't been the best, which is hard to take.*

B27 - *I would say probably my mental health has dipped along with I would say, a high percentage of the population in COVID.*

4.6.1.2 Theme Two.

Title – Poor at Taking Breaks

The clergy in this sample, stated they were poor generally at taking breaks and getting the rest they required. This appeared to be due to feelings of duty, responsibility or calling.

B11 - *We tried to make Mondays our day off, but it notoriously didn't happen for a variety of different reasons, because there's always something that needs to be done. So, we'd both say that neither of us are particularly good at protecting our time in that respect.*

B21 - *Well, it does vary to be frank and I'm not particularly good at days off if I'm totally honest.*

4.6.1.3 Theme Three.

Title – Self Pressure, Unrealistic Work Goals, Fear of Letting Others Down

One potential rationale for the poor levels of breaks and rest in this group is a sense of self-pressure, self-imposed unrealistic volumes of work, and fear of letting others down.

B2 - *…the job can sometimes take over a bit and sometimes you put unreasonable pressures on yourself … You think you're doing it because the church expects it, but actually people don't necessarily expect you to do all those things that you end up trying to do, and it's actually just you yourself that's putting that pressure on yourself.*

B17 - *But when you're in ministry, it strikes me as it's all your problem and it never really goes away. …but I think the whole lot becomes a bit of a calamity, a perfect storm, and even the things that you're self-aware about, you don't do as well as you know you should be doing, and then you beat yourself up about it and feel worse.*

B20 - *…I started to suffer from real anxiety and panic attacks, and it was depression. And I've never experienced it before. It came as a big shock to me … that I was letting people down, that I was a failure.*

4.6.2 Christian Community Network

This category explored the barriers to self-care created by the Christian community network across two themes.

4.6.2.1 Theme One.

Title – Don't Have Friends at Church

Sub-theme:

- Work and friendships blur and can have negative consequences.

One of the most discussed aspects of ministry in this group was the issue of having friends in church, if it was possible to have friends in their congregations, and

some of the negative consequences some ministers have experienced in these relationships. One participant summarised the concern: “Been there, done that and got burnt I would say” (B27). This participant discussed a possible rationale for the friendship complexities with regards to the relationship having two levels, minister and friend: “Sometimes though in a church setting if you do something that that person disagrees with it can lead to them withdrawing their friendship” (B2). A further participant elaborated on this:

B5 – *I’ve never been able to be friends with people in my church. Partly because you’ve got a duty of pastoral care to them. I’ve had quite a few people stab me in the back as a minister from time to time, which is painful, especially if you think that they’re your friend. People leave churches over stupid things, and it hurts greatly when that happens.*

Other clergy discussed the necessity to maintain boundaries so they could minister to their congregants in a suitably beneficial way and discuss the hard topics.

B18 - *But I remember one particular situation where a guy I had played with several times and his marriage was in a bit of a mess really. And he came to see me in the house and went to my study and we sat down, and I realised that we’d entered the banter of friendship. And as we sat down, I realised I need to change gear, otherwise, I was not going to be able to help him. I need you to be his pastor, not his friend at that moment, I also needed to challenge him.*

B9 - *You know there are people who I would consider friends within church. But I’m also really acutely aware of the tension of being someone’s friend at the same time as being their minister. Which just sometimes makes things a little more complex than if you weren’t their minister.*

It is evident from these responses, and the previous facilitator responses regarding friendships in church, that this is a very complex issue for clergy in this group.

4.6.2.2 Theme Two.

Title – Role Pressures From Congregants

Sub-theme:

- A few support, most don't.

Several clergy cited the lack of support from their congregation, this appeared largely due to a lack of understanding of their role, demands, pressures, and complexities.

B24 - *To be honest … if I was to ask any of them what do I do day to day, most of them would say you just work Sunday's, don't you?*

B21 - *I think there are some folk that have a reasonable understanding of that, but I think the general, the average person in church probably has little concept of what is involved and what the strains and stresses might be at a particular time.*

B3 - *…this last nine months of COVID, its demonstrated that a lot of people don't actually understand what goes on in a pastor's work and mind…*

There appeared to be a significant demand from their congregations to care for the community which was not readily reciprocated to the minister when it came to general support, or support for rest and necessary reflection.

B17 - *I think there's a culture of yes, we look after ministers, but in reality I think we look after churches better than they look after ministers.*

B10 - *It feels like a lot of, any sort of support is self-generated, so I have to almost like ask for support.*

4.6.3 Societal / Policy

This category explored the barriers to self-care across one theme relating to societal and policy factors.

4.6.3.1 Theme One.

Title – No Health and Wellbeing Policy

This group unanimously cited that they did not have any formal health and wellbeing policies in place. They discussed general safeguarding etc. for the church community, and one participant (B24) discussed developing a mental health policy born out of challenging situations during lockdown. Another stated: "…it's been really brought into focus by the pandemic, that there is a need to have a wellbeing policy … we don't have anything formal yet, but I think it's one of those things that's going to be very much at the top of our agenda" (B20). Upon discussion of the lack of formal policy in the interviews, several stated that this was something that they should perhaps work on e.g., "Probably not, actually, it's something that you raised, that's probably something on a to do list that I need to look at" (B8) and "We don't have a specific policy that covers that, and that's an interesting question, and maybe it's one to take back to the team…" (B16).

4.6.4 Interpersonal

This category explored the barriers to self-care relating to intrapersonal factors across two themes.

4.6.4.1 Theme One.

Title – Lockdown Negatives

Sub-theme:

- Missing informal social interactions e.g., football, jive class etc.

A further barrier imposed by the UK COVID-19 lockdown was the restriction some clergy experienced in attending social outlets. Several clergy commented on how restricted they felt in these usually supportive social events:

B4 - *The fact we've not been able to do the ride outs we would normally do this year, we'd normally have a week in Scotland or something, and stay at a youth hostel or whatever … So, not being able to do that has been really tough.*

B8 - *…when I think about my social health, which is attached to the physical health, the thing that I've missed the most because of lockdown is playing football on a Monday night.*

B5 - *Jive class … it was a good social outlet on a Monday night. And we haven't been since … but it was great because Monday night was jive night and I protected that.*

4.6.4.2 Theme Two.

Title – Don't Always See Closest Friends. Try to Maintain Relationships From a Distance

In addition to the previously identified complex social relationships in this group, a frequently highlighted theme regarded their closest friendships being maintained at a distance, with infrequent in-person contact.

B5 - *…we've maintained friendship with them over the years, but because one lives in* (Location) *one lives in* (Location) *it's difficult to actually have a regular meet up or get together so we don't do it that often.*

B16 - *I have a wide circle of friends spread out all over the place as I guess it's the norm these days.*

B21 - …there is one interesting couple that are nothing to do with our church, don't even live close, they live probably 50 miles away … who are probably in the category of our best friends.

B23 - *…my best friend doesn't live too far away, so that's quite good. He's still 50 miles, but it used to be about 200, so that's pretty good.*

These distance relationships, coupled with the other challenges of friendship in church, highlights a potential issue in maintaining good social health in this group.

4.6.5 Institutional / Organisational

This category explored the barriers to self-care created by institutional and organisational factors across five themes.

4.6.5.1 Theme One.

Title – Lockdown Negatives

Sub-theme:

- Rapid technology skill building and overuse.

A further negative of the COVID-19 lockdown period was a significant overuse and overreliance on technology. Some felt that due to the lack of IT skills within the church community, much of the work to keep the church running virtually fell to them e.g., "I'm horribly indispensable in terms of even just the functioning of

a live stream … and even though we have lots of great people in the church trying to team build at a time like this, it's really, really hard" (B4).

Others cited the mental and physical draining nature of the rapid shift to extra technology use:

B10 - *…lockdowns made it worse because your mental energy is drained as well from always being on Zoom …*

B11 - *…the challenge with all of that is that you prepare your service like you would normally then you go and record it, then you gotta come back and edit it, so it takes two or three times longer than it would do if you were actually delivering the service on a Sunday…*

B27 - *I had never heard of Zoom or Teams before lockdown … We have our services on Zoom, we have church meetings on Zoom, prayer meetings on Zoom, individual chats on Zoom. And so, I had to have my eyes tested in February … my eyes were under terrible strain, you know they hurt sometimes and my head aches.*

Although online meeting platforms have proved effectual for maintaining a degree of normality during this global disruption, it is evident that for some within this group, this has caused a significant degree of pressure, physically, mentally, and occupationally.

4.6.5.2 Theme Two.

Title – Lack of Self-care Training at Theological College

Sub-themes:

1. Received little or no training on self-care at theological college.
2. Witnessed colleagues' / graduates' lack of adequate self-care knowledge and skills.

Most participants stated they received no formal training at theological college regarding health, wellbeing, or self-care. Despite many receiving their training a number of years ago, several participants stated they had observed recent graduates with a similar lack of knowledge and skills in this area. One participant stated: “I am disturbed, just listening to the comments of people who come out of colleges having finished ministry training courses. I’m disturbed about the lack of adequacy of what’s been offered” (B19). Additionally, another participant stated, “I would say people coming out of Bible College, seminaries, should be coming out with a good practice already embedded in them, but I don’t know how much that happens” (B2). Reflecting on their own experience, a further participant stated: “…I don’t want to sound overly critical, but I think it did not focus on the individual wellbeing of the minister … I didn’t think that was ever part of the picture in anything like sufficient amounts” (B21).

A further participant summed up the general feelings of the group:

B8 - *There is so much that we feel like we have to carry that I think that, how to love yourself, so that you can love, and so that you can serve, really doesn’t get emphasised a lot really in that formation and training.*

A potential reason for this lack of self-care focus was summarised by a further participant when discussing the formal academic nature of theological training:

B16 - …*the place where I did my training at* (College name and location) *which of the Baptist colleges, it’s probably the most academically focused at of all our training colleges. So that’s where the energy goes, certainly in trying to push you academically.*

4.6.5.3 Theme Three.

Title – Only One Full Day Off

Most participants stated they only had one full uninterrupted day off for personal rest per week. Several cited the Jewish sabbath principle of sundown to sundown to take one full 24-hour period spread across two days:

B16 – *Usually, I take Saturdays as a day off so, often I do it in the kind of Jewish sabbath principle of sunset to sunset. So, Friday night, once it gets to dinner time the evening then I down tools and I have Friday night, and then through to Saturday dinner time as a complete day off.*

B23 - *I try to have this idea of like Sabbath rest starting on Friday afternoon evening. So normally from when I start, when I leave the church to pick up the children, I try to have some rest.*

Some cited they may take some evenings during the week, or one day off plus a separate sabbath day, however, the majority stated they had only one full 24-hour period of rest per week.

4.6.5.4 Theme Four.

Title – Personal Spiritual Engagement is Restricted / Directed by the Role

Sub-theme:

- Recognise the need to separate personal and work spirituality.

In addition to the complexities of friendships within this group, the other most highly discussed facet of health was spiritual wellbeing. Some discussed the difficulties in separating spiritual activities for themselves, or for the church:

B8 - *…in terms of being a minister, the spiritual health is really complex. …if you work for the church it kind of feels like, when you wake up and spend time praying or reading your bible, is that for church or is that for me?*

B6 - *A lot of times during my holiday, I don't tend to read the Bible or pray as much because it just reminds me of work.*

B17 - *…it just becomes a chore to do anything, and I found for me, I lost my way in what was my own spiritual devotions and what was the stuff I was having to churn out every week. That has never really fully recovered.*

B3 - *You end up by reading the Bible and praying, because you've got a list of people that you promised to pray for, and therefore that's part of the job, and because you've got events that are coming up, and situations that you need to pray for…*

One participant succinctly summed their feelings by saying "I do struggle sometimes with me and God being work colleagues…" (B10)

A further participant discussed the blurring nature of the role in their personal spirituality:

B12 - *…because it's not a secular job. It's not like I'm a bus driver, but I'm not driving the bus. I can't drive a bus coz I'm at home, it's definitely separate. Whereas for a minister you can engage with God through your work and engage with God in your downtime, so that is blurred.*

Some discussed the challenges of separating work from personal time with God, and stated the necessity for intentionally separating the two to have spiritual time for themselves before others:

B9 - *I feel like there's been times over the years where I have been reading the Bible for what God might wanna say to others and it's not a healthy or*

sustainable place to be … I've found I've got to read it for myself, I've got to be with God for myself, if I can't lead myself then I can't lead others.

B16 - *…it's making sure that in my mind I separate off this is time for* (Name) *and this is time for the ministry. …I mean, sometimes inevitably there's overlap…*

It was evident in this group that there were complex feelings around the maintenance of their personal spiritual health whilst navigating the necessary occupationally related spiritual practices.

4.6.5.5 Theme Five.

Title – Sometimes the Job Takes Over / No Limit to the Role

A final highly discussed demand on clergy, was the role having no set limits or boundaries, and as such, becoming all consuming:

B18 - *Whether you're a part time minister or a full-time minister, you're always wholly the minister. You're never not the minister. …and it's a bit like being a parent in some ways you know. I was never not Dad. I might have been asleep but I was still Dad.*

B19 - *The difference with people work is that you could spend 24 hours a day seven days a week and there would still be stuff to do.*

B21 - *I feel all of those lines are fairly blurred. So, if there's a real problem in the Church it dominates the whole of my life, and I can't kind of walk away from it.*

B11 - *…work as a minister is a calling, so it's a vocational thing, it's not a case that you are working from nine to five and get renumerated from that, it's much bigger. The inherent understanding that, therefore, it's a serving role, it's a sacrifice and there is no end to the demands.*

Due to the demanding nature of the role, self-care can be at risk. This participant summarised some of the challenges of the never-ending role: "…you begin to cheat yourself for the sake of other people. So, you begin to try and squeeze more in, and try and do more, which means that your mental emotional health can feel a bit more squeezed, your spiritual health, you just ask for forgiveness and a quick God help me and forgive me (laughs) I haven't spent any time with you for a week" (B8).

Evidently, within this group, work life balance was a significant challenge and posed a substantial potential holistic health barrier.

4.7 Discussion

This second study was conducted as a sequential response to the findings of Study one and the lack of UK Baptist clergy insight into self-care practices, namely the perceived barriers and facilitators to holistic self-care practices. Study one indicated unique deficits in select areas of health. This study, therefore, sought to gain a deeper understanding of some personal beliefs and rationales surrounding self-care behaviours using qualitative semi-structured interviews informed by the theory of planned behaviour. Reflexive thematic analysis was conducted on the data using a six-stage framework (Braun et al., 2022; Braun & Clarke, 2006)

The research question addressed by this investigation was:

- What are the perceived barriers and facilitators to the holistic (physical, mental, spiritual, and social) self-care practices of UK Baptist clergy?

4.7.1 Observations and Interpretation of Findings

A significant initial observation from this investigation, was that clergy discussed health in a multifaceted way. The initial strategy to conduct barrier and facilitator thematic analyses for the select domains of health under investigation quickly required adjustment. Instead, the socioecological model of health was used to explore the facets. This observation highlighted the complexity of real-world holistic health practices and perceived influencing factors in this group. Additionally, these findings also highlight the necessity for pre and post-training, policy, and BUGB support strategies, to consider self-care holistically. In a recent physical activity engagement investigation, using a similar methodological strategy to the present study, comparable findings were generated regarding the complex influencing factors to self-care engagement. The authors too suggest a recognition of holistic factors in policy and practice for sustainable change (Eyre et al., 2022, p. 10).

The findings from this study call into question the support (perceived and actual) clergy have to maintain their personal health and wellbeing. It is known in occupational health and wellbeing that there is a place, and arguably a need, for multi-level, primary, secondary, and tertiary, health and wellbeing interventions. These interventions support individuals when symptoms begin to arise, but they are still able to work e.g., stress (secondary) or when a person is diagnosed with a mental health issue (tertiary) e.g., counselling. What appears to be lacking, from the experiences of this group, and the research of available UK Baptist services, is primary support. It was almost unanimously agreed within this group that self-care training was lacking in their pre-placement education. It is acknowledged, however, that the clergy role is complex in that they are not classed as employees, but rather

office holders, which does place health and wellbeing onus on the individual rather than legally on any organisation or individual church. That said, the biblical imperative to self-care is clear, and as disciples in Christ, irrespective of the lack of any legal obligation, organisations may have a theological and indeed moral imperative to provide suitable training and support for clergy holistic health.

The results from the present investigation most notably indicated that some of the generated themes appear the same, or similar, to the identified themes in Proeschold-Bell et al.'s (2011) clergy health barrier and facilitator exploration. Although, this data is not from Baptist ministers, it is suggestive of similar strains and stressors that may impact holistic health and self-care behaviours. The clergy in Proeschold-Bell et al.'s (2011, p. 708) investigation cited:

- Lack of understanding from the congregants regarding their role
- High expectations and demand from congregants
- High job demands due to complex roles
- Putting the needs of others before their own
- High self-pressure

The current findings also align with other US Methodist work which similarly suggested clergy in their investigation have a demanding role, experience unrealistic congregational demands, and put the needs of others before their own (Lindholm et al., 2016, p. 104). Further still, another US Protestant study showed similar clergy self-care barriers, where they felt overwhelmed by the job demands and pressures, difficulty in congregational relationships (lack of trust) lack of close friends and isolation (Hill et al., 2003). Finally, an evangelical Protestant investigation evaluated by McMinn et al. (2005) showed very similar findings to the

present study, where pastors found challenges in their personal spiritual relationships, strength from accountability and peer relationships, hobbies, and time out and / or away. In addition to similar barriers and facilitators in these international investigations, the present study also highlighted specific health concerns in the social and spiritual domains. Social support in particular, is cited as being an important factor for personal wellbeing (Lee & Iverson-Gilbert, 2003; Wells, 2013; Zavaleta et al., 2017). The data generated from the present study adds to the research field, further strengthening the argument for the complex nature of clergy health in some denominations, and the need for interventions.

Proeschold-Bell et al. (2017) found significantly poor presenting health and self-care practices in their Methodist ministers. The intervention sought to radically overhaul the health of ministers (many presenting with significant co-morbidities) by using a multimodal intervention delivered by health care professionals. Notably, the results from this thesis' investigations show similarities with this and other international literature. The question arises therefore, should institutions and agencies be investing in the health of their clergy by offering training, monitoring, and support pre and post-seminary to promote improved health and role function using a similar model to Proeschold-Bell et al. (2017)? Overall, these works suggest a need for improved support strategies, and most importantly, further research regarding the suitability, feasibility, and acceptability of models of support for UK Baptist clergy.

It is evident from the present study that clergy self-care practices in this group are complex. This study (and this thesis' previous quantitative investigation) has uncovered some notable preliminary UK Baptist data and added to the trans-denominational research pool regarding the occupational health needs of clergy.

What has been clearly highlighted is the need for more research and strategies to support these influential office holders (Harmon et al., 2021) and by extension, the communities in which they serve.

4.7.2 Directions for Future Research

This study indicated that positive holistic self-care engagement in this group is complex. Based on the findings, the following provides suggestions for future research directions:

Clergy appeared to be able to discuss facilitators for self-care practices more easily than barriers, thus more themes were generated in this thematic analysis. Further research would be advantageous to explore the rationales for this, as the results of Study one indicate holistic health in this cohort requires some improvement. It would be useful to investigate for example, if this is due to wanting to appear healthy, due to the innate nature of the clergy role as being on display to the community. Conversely, it may be useful to explore if clergy lack the knowledge base to articulate the precise areas necessary for improvement, or practices which may produce negative effects on health and wellbeing.

Due to the nature of the qualitative design, results of this investigation cannot be generalised to the wider Baptist clergy population, nor was this sought. However, further quantitative exploration, using the generated themes as a basis would be advantageous, to determine if the highlighted barriers and facilitators are felt more widely across the population. Such exploration may assist policy makers to produce guidance that is widely relatable, useful, and applicable to the wider UK Baptist clergy community.

Given the almost unanimous agreement in this group, regarding the lack of ministerial self-care training, it would be advantageous to explore the acceptability and effectiveness of specific self-care training modules and programs delivered by trained practitioners. This approach would offer primary prevention for poor occupational health and wellbeing. This approach of dedicated and trained health personnel is similar to that of Proeschold-Bell and Byassee (2018). Despite being delivered by healthcare personnel, seminary training could feature cohort specific biblical rationales (as cited in this study) in an attempt to prompt personal individual improvements in self-care beliefs and behaviours.

4.7.3 Strengths and Limitations

This study is the first UK study, to date, to qualitatively explore holistic health beliefs and behaviours in UK Baptist clergy. This study offers a unique contribution to UK clergy research and the wider international research field where clergy investigations are scant.

The methodology adopted in this investigation attempted deep reflection, reflexivity, acknowledgment of the potential influence of the author, and rigour practice. This approach, although potentially rejected by some other ontological stances, is a transparent reflection of the author's approach and impact on the piece, seeking to support the reading of the data interpretation (Ballinger, 2004; Braun & Clarke, 2019; Braun et al., 2022; Mays & Pope, 2000).

Although the results of the present study cannot be generalised (by statistical probabilities) to the wider Baptist clergy population, as the results from this study bear significant similarities to other clergy research, a degree of naturalistic generalisability may be assumed. Given the wider international works the current

study bears similarities that may be recognised by other Baptist clergy and readers through their own experiences or observations (Hays & McKibben, 2021; Smith, 2018; Tracy, 2010). Additionally, due to the clear similarities to other works, the current study may be considered transferable, in that the results may be transferable to other settings (e.g., other churches, or locations etc.) (Hays & McKibben, 2021; Smith, 2018; Tracy, 2010). Following on from this, the work may also elicit generativity, where a reader is prompted to act, as they have been impacted by the testimony of another (even if they do not directly identify with it) (Smith, 2018). This is a particularly useful consideration, given the support strategies clergy use, namely peer to peer sharing and mentorship, and learning from the experiences of others. Although generalisability is not sought in qualitative research, representativeness is important, particularly in the context of this novel study, as it can open or close doors regarding what future research is conducted or its overall importance (Smith, 2018). This is an important consideration particularly in occupational psychology research where works can form the basis of significant workplace health and wellbeing change. As such, the exploration of forms of generalisability in this study is considered a strength (Darnell et al., 2018; Smith, 2018).

A potential limitation of this study resides in its one-to-one interview design. As discussed by all participants, clergy in this group appear used to engaging and discussing practice and personal concerns with their peers. Ergo, different, or even richer, results may be generated using a focus group design. Peer to peer discussion on topics may aid the flow of conversation and may help tease out challenging topics that may otherwise be limited or avoided when discussing them one to one with a perceived outsider. Although this design may produce different findings, the data

produced in the current study was rich, and sufficient to gain a suitable understanding of some of the complex holistic challenges faced by this group.

4.7.4 COVID-19 Impact

A final limitation in this study were the UK COVID-19 lockdowns and how these restrictions impacted the health and wellbeing of participants. A prominent feature in the group's responses were the pressures and some positives of the lockdown periods. It is noted, therefore, that if these interviews were conducted in a different period, different topics may be brought to the fore. Additionally, the lockdown period, as shown in some of these participants' responses, had a negative mental effect on many UK citizens (Mind, 2021; Vizard & Joloza, 2021). As such, some responses, including reflections on time demands, breaks, and limitations on socialising, may be influenced to a degree by the ongoing impact of the restrictions.

All interviews in this study, due to the ongoing social distance restrictions, were conducted online using video conferencing software. There is potential that the overuse of technology due to social distancing, may have prevented some from being involved in the online interviews who would have otherwise engaged in a face-to-face interview. These COVID-19 specific limitations and the aforementioned focus group design could be easily addressed with slight modifications in future iterations.

4.8 Chapter Conclusion

Qualitative interviews were conducted with 20 UK Baptist clergy. Data from these interviews highlighted complex lived experiences of holistic self-care that appear to be significantly influenced by their roles. Clergy in this sample indicated prominent barriers to health, particularly in the social and spiritual domains. Some specific facilitators were highlighted, including the necessity to take time out, the

experience of the notable inter-relationship with the health facets (mental and physical) and select biblical imperatives (e.g., the example of Christ).

These data and generated themes provide a unique insight into the complex self-care beliefs and behaviours of UK Baptist clergy. It is the first study, to date, of its kind. This study offers a valuable contribution to clergy health and wellbeing research. Additionally, the current study has also provided data from which to build future research investigations, interventions, and promote internal (BU, individual church, and peer to peer) discussions.

Chapter 5: An Exploration of the Existing Literature Pertaining to Health and Wellbeing Interventions in Christian Clergy: A Systematised Review.

5.1 Introduction

After the collection and analysis of data from the first two studies, it was evident that UK Baptist clergy experience some health deficits and inequalities against comparative adult populations, drawing similarities with other clergy literature. As such, an aim of this thesis was to explore the potential of a tailored behaviour change intervention to positively influence self-care. Prior to designing an intervention, a systematised review of the literature was conducted to capture key features of successful clergy health and wellbeing interventions. This stage of investigation was a foundational step prior to this thesis' final intervention study. The following chapter describes the methods and findings of this review.

5.2 The Systematised Approach

A systematised review incorporates the robust framework of the systematic review and allows for solo postgraduate researchers "to demonstrate an awareness of the entire process and technical proficiency in the component steps" (Grant & Booth, 2009, p. 103). The systematised approach, however, cannot be considered a systematic review due to the approach using one reviewer, thus creating potential review bias (Grant & Booth, 2009). Despite this potential limitation, the systematised approach still allows for a rich exploration and reporting of a wide range of articles and items within the search field (Day & Petrakis, 2017, p. 634). This review, due to its broad inclusion of grey material and student works, will not use a formal quality assessment, which is optional in the systematised approach

(Grant & Booth, 2009). Instead, this review seeks to explore and categorise key characteristics of existing clergy interventions.

5.3 Aims

The primary aim - To explore the existing literature pertaining to health and wellbeing interventions (any facet of health) in Christian clergy (where church leadership is their primary job role).

Why – To explore what has taken place previously in view of informing a tailored feasibility study for UK Baptist clergy. Examining and extracting key characteristics, approaches, methods, and tools to include to promote maximal fit and efficacy in an intervention.

5.4 Method

This systemised literature review followed a systematic line strategy to capture the maximum number of key relevant articles from select data bases. The review was guided by a specialist research librarian at the University of Nottingham. The process began by exploring outcome questions, aims, possible exclusion criteria, keywords, synonyms, truncation, Boolean operators, wild cards, and word proximity (the final selected wording can be viewed in Appendices J and K).

5.4.1 PICO Strategy

Search terms were identified by examining each word in the search question and its synonyms and applying the commonly used PICO strategy (Booth et al., 2019; Cherry & Dickson, 2017; Petticrew & Roberts, 2006). This strategy seeks to deconstruct a search question into its component parts: Population, Intervention, Comparison, and Outcome. Some reviews also include an additional ‘C’ (context) or

similarly ‘SS’ denoting specific study design and setting (Cherry & Dickson, 2017). In the case of this review, a pragmatic approach was taken to the acronym selection, as a small output volume was expected. The broad ‘PICO’ was selected due to its popularity and known effectiveness in systematic reviews. Additionally, this avoided restriction of the search with additional parameters such as stakeholders.

Ergo, for “Health and wellbeing interventions in Christian clergy”, this was extrapolated as:

Population - Christian clergy

Intervention - Health and wellbeing interventions (any or all facet/s of health)

Comparison – Measurable change in health behaviours / health outcomes, behavioural model, or areas of physical / mental health (e.g., BMI)

Outcome – behaviour or health outcome change

5.4.2 Inclusion Criteria

Due to the limited volume of published works pertaining to clergy health and wellbeing in the UK and internationally, the inclusion criteria for this review were broad. Studies were included in this review if they met the following criteria:

- Works should focus on practising trinitarian Protestant Christian Clergy (any denomination) where church leadership is their primary role.
- If clergy are combined with other professional groups, works will only be included if clergy results can be differentiated.
- Works must be published in English.
- The goal of the work should be to positively improve personal clergy health and / or wellbeing in any facet.

- Any methodology and any sample size would be considered.
- The intervention steps should be methodical, presenting a clear picture of what participants engaged in.
- Published works, grey literature, and supervised student works, where intervention processes are publicly available, would be considered.

5.4.3 Data Collection - Initial Search for Existing Reviews

The process began with an initial search for existing systematic and systematised reviews on the 6th April 2021 using the search term 'Systematic review of health and wellbeing interventions in Christian clergy'. Subsequent searches included shortened and adapted phraseology: 'Systematic review Christian clergy', 'Systematic review Christian', 'Systematic review pastor, minister, vicar, priest'. The databases Google Scholar, Scopus, ESCO, MEDline/NIH, APA, DARE, and Cochrane were searched. A single item focussing on psychological health influences in Christian clergy was returned (Edwards et al., 2020). Although not focussed on health and wellbeing interventions, the professional pronouns used in this article (published in the notable journal Mental Health, Religion & Culture) guided the development of this thesis' systematised review search strategy. This preliminary step, despite not revealing any existing clergy health and wellbeing intervention reviews, highlights the novel contribution of the current review.

5.4.4 Data Collection

5.4.4.1 Year Span.

This systematised review was limited to the 2001 – 2021 year range to facilitate the capture of contemporary health literature and practices.

5.4.4.2 Initial Medline OVID Search.

The database Medline OVID was initially searched for subject headings and multipurpose keywords using the following five terms.

1. Health
2. Wellbeing (well-being)
3. Intervention (Program)
4. Christian
5. Clergy (Pastor)

This initial search returned 763 results, including many irrelevant titles. The purpose of this initial step was to gauge a rough output volume, types of results, and consider how many outputs matched the search criteria. The refinement process (see Appendix J) sequentially edited these key search terms to modify or remove terms that drew irrelevant results.

5.4.4.3 Databases.

Using the identified keyword search terms, five databases were searched. Following these, a further four databases specialising in theses, dissertations, and grey literature were subsequently searched. These databases were selected due to their stated scope and suitability in relation to the occupational psychology field.

Databases searched:

1. Medline OVID
2. APA PsychInfo
3. Web of Science
4. Scopus
5. Proquest

6. BASE (grey literature)
7. Open Grey
8. Ethos
9. Worldcat

This database search was followed by a simple Google search to capture any grey literature not already explored. No further items were identified from this final search step.

5.5 Results

Using the tailored keyword search line strategy (Appendix K) the following results were generated (Table 29):

Table 29
Number of Retrievals from Individual Database Search

Database name	Number of initial results	Final number of results for further review [a]
MedLine	594	16
APA PsychInfo	825	16
Web of Science	630	5
Scopus	863	1
Proquest	1122	9
Base (grey literature)	9	0
Open Grey	10	0
Ethos	50	2
Worldcat	30	0
	Total number of works assessed for eligibility	49
	Type of evidence	
	Journals	28
	Thesis / Dissertation	21

Note. Databases were searched in the order presented.

[a] Denotes the final number of results selected for review after removing inappropriate results and duplicates (starting at row two) from the previous search's initial results, determined from reading titles and abstracts.

From the initial search, 49 items were selected for review. Twenty-five items were further excluded as they did not meet the inclusion criteria of being a clergy health and wellbeing intervention (e.g., they were aimed at theology students, catholic priests, or were theoretical plans only, not interventions). This left 24 articles which used some form of intervention to positively impact the health and

wellbeing of clergy. Of these, seven articles were by the same research group pertaining to the same two-year clergy study. Therefore, only one article (Proeschold-Bell et al., 2017) was included, which comprehensively detailed the steps taken in the intervention. A further thesis was excluded, as the author published a peer reviewed journal article describing the walking intervention in detail that was included in this systemised review (Webb & Bopp, 2017). A final total of 17 items remained for full review, 10 journal articles and seven theses. Among the included theses, one (Emmons, 2015) required an interlibrary loan from a US institution that was kindly provided free of charge from Regent University.

Of the 10 peer reviewed published works, three appeared in The Journal of Religion and Health. This journal was, therefore, hand searched from volume 40 – 60 (2001 – present) this, however, did not yield any further results.

In addition to The Journal of Religion and Health, the remaining published works were featured in five other journals with no obvious pattern:

American Journal of Preventive Medicine

Journal of Pastoral Care and Counselling (two articles)

Journal of Psychology and Theology

Pastoral Psychology

Spirituality in Clinical Practice (two articles)

The reference lists of the 17 included items were scrutinised for any further intervention articles, this yielded two further linked studies regarding the same intervention. The first was included (Rosik et al., 2009) and the follow-up study was commented on (Rosik, 2011). The items retrieved at each stage can be viewed in Table 30.

5.5.1 Summary of the Systemised Review Process.

Table 30
Items Retrieved at Each Stage of the Search Process

	Search action taken	Number of items
Search 1	Search for existing systematised / systematic reviews	0
Search 2a	Initial five item search of Medline OVID (Health, Wellbeing, [well-being] Intervention, [Program] Christian, Clergy [Pastor])	763
Search 2b	Refined search across all nine databases	4,133 (49 selected items assessed for eligibility). On first reading 25 of the 49 did not meet the search criteria, seven items were discussing the same intervention, and only one was included. One further article's intervention was duplicated from a thesis. *N*=17 items remained for review (ten journals and seven theses)
Search 3	Google search for additional denomination specific grey literature	0
Search 4	Hand search of the Journal of Religion and Health	0
Search 5	Reference list search of the selected 17 items	Two interrelated articles identified, one included.
	Final total number of works included in the review	18

5.6 Reviewed Studies' Key Characteristics

Table 31
Reviewed Study's Key Characteristics

Number	1
Author, year, publication type, location	Abernathy et al. (2016) journal, USA.
Participants, and sample sex	No program data provided on overall sample size or denominations. This article focusses on one case study, a Baptist pastor, and his wife.
Study design	'Pastors Empowerment Program', support for clergy in the aftermath of Hurricane Katrina. Aims – "…enhance the self-care and psychological resilience of pastors and their spouses/partners…" (p. 175). A multidisciplinary psycho-education three-year program with a three-day annual retreat workshop focussing on "Phase 1: Self-Care, Phase 2: Resilience, and Phase 3: Cultivating Relationships" (p. 179). The intervention featured clinical psychologists, a spirituality and health therapist, a trauma and stress specialist, a Baptist preaching professor, and a worship leader specialising in the psychological and spiritual care of clergy. The format entailed teaching, "followed by dyadic work and group discussion, spiritual practices, and meditation" (p. 179).
Main findings	As well as developing their knowledge base regarding stress, resilience, and their intimate relationship, the case study couple stated "They were thankful for a safe space for this kind of intimacy. Being with others who had similar struggles and having the opportunity to share with the group made them feel less alone" (p. 183 -184).
Strengths	This program used a multidisciplinary team of professionals with cultural and religious awareness to sensitively deliver the intervention.

Limitations	This article does not present any cohort data (other than the case-study) therefore the effectiveness of the intervention cannot be determined. The study relies on participants availability to attend three annual three-day retreats during the aftermath of traumatic incidents, which may contribute to participant attrition.
Number	2
Author, year, publication type, location	Cuthbert et al. (2018) journal, USA.
Participants, and sample sex	*N*=71, mixed sex, nondenominational evangelical Protestant, Louisiana and Michigan (p. 230).
Study design	A four week (16-day) 16-exercise workbook activity on humility "Positive Psychology Intervention" (p. 227). All exercises were completed with a self-selected partner. The workbook featured biblical text examples, activities, prompts for personal reflection, and activities to be completed with their chosen partner. Staggered intake with an initial cohort followed by a waitlist control group.
Main findings	No statistically significant positive effects on humility or life satisfaction were found, however, accuracy in self-report perceptions of personal relational humility increased. No consistency in participant feedback on the usefulness of activities were found, with some highly ranking certain activities, where others ranked them as least helpful.
Strengths	Honest reflections from the team who cite the approach of Bolier et al. (2013) "…we encourage researchers to publish in peer-reviewed journals, even when the sample sizes are small or when there is a null finding of no effect, as this is likely to reduce the publication bias in positive psychology" (p. 17). The workbook activities included spiritually sensitive material.

Limitations	The team stated that the smaller sample size and lack of randomisation on the sample may have contributed to the lack of significant findings. Some participants reported thinking about the action-oriented exercises rather than fully completing them, not completing the program as intended (p. 238).
Number	3
Author, year, publication type, location	Cutts et al. (2011) journal, USA.
Participants, and sample sex	'Life of Leaders Program', an existing intervention run out of a UMC healthcare centre in Memphis. The article does not discuss results, efficacy, acceptability, or demographics of participants. The article states that 10 – 12 participants per cohort were selected from similar occupational backgrounds (e.g., missionaries).
Study design	A holistic intervention comprising "…a two-day executive physical and leadership development retreat" (p. 1319). Health information is collected pre-retreat and participants receive selected books and CDs to support their holistic health. The past five years' medical care on each participant is collected from their healthcare provider. Participants have access to "…physicians, health coaches, dieticians, exercise physiologists, acupuncturists, massage therapists, and Pilates and yoga instructors" (p. 1319). Participant physical assessments include blood tests, dietetics, and mobility assessments "…optometry examination, gross hearing screening, spirometry, chest x-ray, full chemical panel of bloodwork and EKG" (p. 1319). Day two focusses on helping clergy interpret their tests. Tailored advice is provided alongside taster sessions on self-selected areas (e.g., meditation, nutrition, massage, and sleep therapy etc.). Post-intervention check-ins are conducted quarterly the following year with a life practitioner coach, and participants receive a small gift.
Main findings	Data and results are not available in this article.

Strengths	Clergy were encouraged to seek permission to attend from their hierarchy and congregations, promoting community support in their decision to take time out for their health. The study recognises the complexity of clergy roles. The study has a clear socioecological framework and details the desired targets at each level.
Limitations	Data outputs would be beneficial to aid in shaping future interventions.

Number	4
Author, year, publication type, location	Davis (2010) thesis, USA.
Participants, and sample sex	*N*=7 Protestant, mixed sex, Philadelphia PA, denomination unknown.
Study design	An eight-week intervention exploring if "…structured Mindfulness-Based Stress Reduction (MBSR) techniques could lessen the symptoms of burnout, and increase psychological and physical well-being and self efficacy" (p. 8). Effectiveness was measured using self-report data captured at three time points (pre, post, and post + 10 months). The intervention used a modified version of an existing MBSR. Groups met for two-hours per week for eight-weeks. Sessions used, yoga, body scanning awareness, and meditation activities. Participants also engaged in small and large group discussion. Topical daily homework exercises were assigned with audio accompaniment.
Main findings	Results varied across the inventories used, however were generally positive in that negative emotional patterns / symptoms were reduced. Analysis of mean emotional exhaustion scores indicated a decrease in the cohort by the post 10 screening, and depressive symptoms showed a decline in some post-test. Little difference was seen in participant anxiety. Symptoms of interpersonal hostility and paranoid ideation showed a decrease. The most significant results were seen at time three, suggesting the necessity for practice and time for efficacy (p. 60). Qualitative data showed positive outcomes ranging from prompting clergy to designate time to self-care, to supporting inner balance (p. 75).

Strengths	The group aspect prompted clergy to regularly stop and reflect on their wellbeing with the support of their peers. The self-report questions were positively received "It made me stop and think about what I am feeling, and how I am handling stress" (p. 77). One participant found the daily homework burdensome in addition to existing busy schedules. As the greatest effect was seen at post + 10 months, exploration into the views and effects of the homework section from a larger cohort would be useful.
Limitations	The recruitment excluded clergy who were not full time contracted, however, it is known some clergy are bi-vocational, and also at risk of burnout / stress etc. Fewer participants than expected were recruited, perhaps due to the time commitment involved in the sessions and daily homework. The thesis states that they were unable to determine statistically significant effect of the MBSR on burnout in the group. Due to the small sample size, it would be advantageous to revisit statistical analysis with a larger cohort, as the initial self-report data indicated some positive effect, to rule out type II error.
Number	5
Author, year, publication type, location	Emmons (2015) thesis, USA.
Participants, and sample sex	*N*=10 Pentecostal (Assemblies of God). The author states that over 100 clergy engaged in sessions (steps one and two) and 20 were coached by the author.
Study design	‘Healthy Ministers Initiative’ - The author spoke at conferences and meetings to educate on nutrition and exercise (steps one and two). Following these meetings and a survey of 88 clergy, participants indicated if they would like further one on one coaching following a six-step nutrition and exercise plan with detailed handouts. Clergy were ‘accountable’ to the coach (the author) to log and track their progress and challenges. Coaching sessions ranged from daily to weekly,

	depending on the participants' need. Multimodal communication was used including "…phone calls, emails, text messages, face-to-face meetings, and a Facebook group…" (p. 112).
Main findings	Results of the 10 case studies appear positive for improvements in physical health. One participant said: "My life has been forever changed; my marriage has been forever changed; my ministry has been forever changed" (p. 117). Another stated: "…in less than six months I lost 70 pounds and felt like a new person" (p. 129). Participants cite positive changes in weight (42-90 pounds lost) fitness level, personal relationships, and ministry.
Strengths	Education drew on the author's personal experience "…the author would relate his personal story of transformation. This transformation included losing 131 pounds and going from burning out to thriving in ministry and at home" (p. 100). Four of the 10 case study results cited this personal story as a significant motivator for change. Education sessions had a firm biblical foundation and used examples throughout. The study identified the necessity for community support and created a Facebook group: "Participants could encourage one another by posting tips, workouts, foods, temptations, Bible verses, or anything they want to communicate to the rest of the group" (p. 110).
Limitations	There is no clear explanation as to why only 10 participant results are drawn upon. The results do not present any statistical data or indicate the most useful or unhelpful factors of the program.
Number	6
Author, year, publication type, location	Jensma (2016) journal, USA.
Participants, and sample sex	*N*=191 mixed sex, denominations not specified. Chrisitan leaders: "…163 missionaries, 12 pastors, seven spouses of pastors, and nine leaders of para-church ministries" (p. 283).
Study design	'ALONGSIDE' intensive outpatient retreat, three-weeks (weekday). Mainly attended by missionaries. At four time points (pre, start, end, three-month post) assessments were carried out using the Outcome Questionnaire-45. The program used

	four hours of daily professional work "…consisting of psycho-education, group psychotherapy, and individual and/or marital counseling" (p. 281). The program builds on Rosik's (2011) work (entry 13).
Main findings	Positive results were sustained at the three-month post, follow up assessment. A statistically significant decrease in distress symptoms was found at time three (directly post-intervention) which was sustained three-month post.
Strengths	Staff delivering the intervention are registered mental health professionals with international missionary experience. As not all participants met the clinical threshold for 'distress', two analyses were conducted, statistically significant positive results were observed in both groups.
Limitations	The author cites possible bias in their findings, where participants who were keen to complete the program (and to see its success) were the individuals who also completed all four time point questionnaires. Data are, therefore, not available for participants who dropped out or who did not complete all four questionnaires.
Number	7
Author, year, publication type, location	Kanipe (2016) thesis, USA.
Participants, and sample sex	*N*=13 UMC and Southern Baptist, mixed sex.
Study design	Ten-week group trial of regular sabbath rest practice (four-six hours of uninterrupted rest) ending in a half day retreat. Participants initially attended a one-day seminar which aimed to increase basic rest and Sabbath knowledge. After participants self-recorded their sabbath rest time, and if they were not able to observe it, provide rationales as to why. Efficacy was measured at pre, time two, time three, and post point using some or all of the following: "…stress, emotional fatigue, social interaction, and blood pressure measurements" (p. 32). Participants were encouraged to appoint an "accountability partner" (p. 37). This intervention was incentivised with free theology books and a free spiritual residential retreat for all who fully completed the study.

Main findings	All but one participant showed substantial reductions in, "…blood pressure, anxiety, fatigue, and disassociation" (p. 185). Although anxiety and fatigue levels reduced, participants scores were higher than comparative adult populations (p. 185). Participants noted the benefits of rest practice in qualitative responses, with one stating: I never thought this study would amount to anything of significance, or more than a justified day off. Boy was I wrong! I am feeling better than I have in a long time. I'm going to keep doing this after the study is over (p. 203).
Strengths	Notably self-report data showed that few clergy were initially engaging in rest practice. From week four, data showed an increase in participation. The study indicated the importance of hierarchical support. The intervention also highlighted the usefulness of accountability, where the author prompted participants to remain engaged in rest practice at weekly intervals over the ten-week program (p. 208).
Limitations	This study is framed as an intervention, however, should be recognised as more of a feasibility study, as results are not generalisable to the featured denominations due to the small sample size. As this study was incentivised, where those who fully completed it were able to attend a fully funded retreat, reliance on the self-report rest data may provide some inaccurate results. The intervention attracted fewer participants than the expected 20.
Number	8
Author, year, publication type, location	Leach (2018) thesis, USA.
Participants, and sample sex	*N*=6 (two female, four male). ? all Baptist.
Study design	One and a half day intensive health intervention focussing on "…physical, nutritional, emotional and spiritual health" (p. iii). The intervention used multi-disciplinary input, including "...a medical practitioner, a life practitioner, an exercise

	specialist, and a dietitian" (p. 76). The premise of the intervention being as participants strive for better self-care, in turn they will become living examples to their communities. This is an edited version of Cutts et al. (2012) 'The Life of Leaders' project (entry three) renamed 'Leaders' Life Program'. Cutts advised on this thesis project.
Main findings	Although not examined statistically, the program's results indicate that participants increased their knowledge and awareness of self-care (including exercise, sleep, and nutrition). Participants suggested they had learned tips that they could apply to improve their general health, including stress management. One Pastor stated the retreat "Provides a 'wake-up' call" (p. 83). Other feedback included participants "Liked being heard, not judged" (p. 102). Participants suggested a specific women's component may be beneficial in future iterations.
Strengths	The original Life of Leaders project was designed for UMC clergy. It was successfully adapted for this thesis' participants possible Baptists. The project used a panel of lay advisors, which included Cutts, to guide and support the intricacies of the intervention. The designated time away to focus on health and wellbeing prompted strong engagement in the program's itinerary (p. 80). The project aimed to be holistic, devoting time to mindfulness, relaxation, diet, and exercise etc.
Limitations	As this was a student project, the full original Life of Leaders program was scaled down as per student resources. It is not discussed how or why sections were scaled down, and what impact this may have had on results. Some pre-intervention data on nutrition, exercise, and BMI, etc. was captured using self-report methods which may be unreliable. Although the retreat itself was useful for some participants, the study does not discuss sustainability or follow up. This thesis provided limited detail on methodological approach and analysis including statistical examination, relying on personal reflection.
Number	9
Author, year, publication type, location	Muse et al. (2016) journal, USA.

Participants, and sample sex	*N*=23 intervention group, (five mixed denomination including one Baptist) *n*=23 control group. Mixed sex.
Study design	A week-long outpatient multidisciplinary therapeutic intervention "Clergy in Kairos" was offered to participants who showed moderate to severe depression and burnout. Some self-referred, and some participation was mandated by denominational hierarchy.
Main findings	Positive improvements in depression and burnout were sustained at the six-month time point. Statistically significant improvements were shown in elements, emotional exhaustion, depersonalisation, and depression.
Strengths	Which therapists, and what specific strategies were adopted, are not stated in this study's results. However, the "highly personalised" "systems therapy" (p. 153) spiritual and psychological multi-therapist, intensive approach appears to provide statistically significant improvement in clergy depression and burnout in this cohort.
Limitations	Clergy presenting with comparative depression and burnout scores functioned as this study's control group and were not offered treatment or intervention, presenting an ethical dilemma in the study's design. Gender difference was determined in the intervention group but not in the control group, which may present some differences in results. Post-test self-report data may be influenced by clergy's intention to please the therapist, researcher, or organisation, where participation was mandated.

Number	10
Author, year, publication type, location	Muse (2007) journal, USA.
Participants, and sample sex	Sample size details are not provided: "more than a decade of clinical work with hundreds of clergy from a variety of denominations" (p. 183).

Study design	Clergy in Crisis Program. Clergy in distress are invited to a weeklong residential retreat where they have "…intensive dialogue with a team of pastoral psychotherapists, suggested readings are provided between sessions, along with ample time for rest and recreation" (p. 185). Clergy discuss three principal areas, personhood, environment, and leadership style during 12-hours of one-on-one therapeutic discussion.
Main findings	The program has been running for over a decade, open nationally to clergy. Clergy have attended who may not be in crisis but require short sabbaticals and refreshment.
Strengths	The program, through work with a significant number of clergy, have developed a theoretical cycle of clergy burnout and a model of spiritual and biopsychological influences.
Limitations	Although the program has been running for a significant length of time, this article does not provide any statistical data to evidence behaviour change brought about by the programs influence.
Number	11
Author, year, publication type, location	Park (2021) thesis, USA.
Participants, and sample sex	*N*=15 Asian American church leaders. Denominations not specified. Mixed sex.
Study design	'STAP' (Slow to Anger Program). An intervention seeking to reduce levels of anger in Asian American church leaders. Anger scale scores were taken pre and post-intervention. The time commitment of the intervention was reduced from initially five Saturday meetings to one two-four hour meeting executed in three staggered groups. The program involved a teaching component, follow-up one to one meetings, and a personal takeaway formula to use as needed. Participants used

supported reflection to map their own anger journeys in ‘grief journals’ prompted by pertinent questions such as “…What needs to be grieved? What needs to be renounced? Who needs to be forgiven? What needs to be surrendered? What needs updating?” (p. 94). In addition to exploring personal anger journeys, a teaching session was incorporated on the theological principals of anger and the Asian American perspective.

Main findings In qualitative reflection, all participants cited positive take-aways from the program, with many reducing their personal anger, identifying coping mechanisms and triggers. Results from anger scales revealed that two participants shifted from experiencing little anger pre-intervention to moderate anger post-intervention. Some participants reported that they would have liked to have lowered their anger levels further. It would be advantageous to explore efficacy if this study were conducted with the original time commitment. All participants identified ‘hurts’ and ‘wounds’ that were further explored in one to one meetings.

Strengths Progress through the intervention was marked in a humorous relatable way, where participants received an Angry Bird badge at the start and a Cross badge upon completion. The questions for individual and group reflection were posed to the group and the author. This suggests that the author shared their story as a means to destigmatise anger discussions. The author was sensitive to the religious culture and led the groups in guided prayer times.

Limitations The groups did not meet in the same locations or conduct the reflective activities in the same ways across the groups. Groups A and B met in a church and reflected individually. Group C met in the author’s home and reflected as a group. Although a culturally sensitive portion of the teaching section was included regarding demon possession or presence, this could be perceived as coercive. The author led a participant through a ‘deliverance’, and a subsequent repentance prayer time for an identified suicide attempt. This is challenging, as although the intersection of religion and psychiatry (and supernatural phenomena) is documented by many (Dein & Cook, 2015; Woods et al., 2014) suicide attempts are a result of mental illness such as depression. The idea of repentance indicates a sinful act. Illness is not a sin, and it requires strategic multi-level intervention. Prayer and religious coping are well documented support strategies; however, care and caution must be taken when addressing trauma and symptoms of mental ill-health, as in this case. As such, this account raises ethical concerns surrounding the intervention’s safe execution.

Number	12
Author, year, publication type, location	Proeschold-Bell et al. (2017) journal, USA.
Participants, and sample sex	*N*=1,114 UMC clergy. Mixed sex.
Study design	'Spirited Life' – A two-year multipoint intervention aimed at positively affecting clergy in the stress, weight loss, and personal health goal setting domains. The intervention began with a three-day spiritually centred workshop, a further two-day workshop was completed midway, and again at the end of the two-year time point. Clergy participated in monthly health coaching (telehealth) between the workshops, online Naturally Slim program, and three stress management workshops included in the two and three-day workshops (either Williams LifeSkills or meQuilibrium).
Main findings	The intervention showed statistically significant positive improvements on metabolic syndrome, central obesity, elevated triglycerides, low HDL, and hypertension at the $p<0.001$ level. These positive improvements were sustained for the duration of the 24-month intervention. The intervention did not show any statistically significant improvements on abnormal glucose regulation or emotional and mental wellbeing factors such as stress and depression.
Strengths	A significant strength of the intervention, as stated in their discussion, was the attention to religious cultural sensitivity. The theological components included in the workshops were well received and provided a theological imperative for self-care.
Limitations	This study focussed on UMC clergy in North Carolina. The results, although compelling, are not therefore generalisable to other denominations or other regions. The study, as stated in their limitations, relied on self-report data for the mental wellbeing components. The study used three staggered intakes, as such, some cohort contamination may have occurred leading to underestimated final results in the latter groups.

Number	13
Author, year, publication type, location	Rosik et al. (2009) journal, USA.
Participants, and sample sex	*N*=142 Clergy and missionaries Protestant Christian, denominations not stated, mixed sex.
Study design	'Restoration and Personal Growth program' - An intensive outpatient program for Christian leaders. The intervention used the Outcome Questionnaire-45 and Marlowe-Crowne Social Desirability scale to assess progress and change at four time points. Participants experience 10 – 15 hours of professional input, including "…individual, marital, and family therapy, pastoral care, group therapy, psychoeducational groups, psychological testing, and referrals to local physicians for medical and pharmacologic care" (p. 689). Participants are referred into the program. Care is delivered by psychologists, marriage and family therapists, a social worker, and ordained ministers.
Main findings	Statistically significant decreases were observed between the groups pre and post-treatment in Outcome Questionnaire-45 scores. This decrease was sustained at the three-month follow up assessment. Participants rated the top five most helpful components as: individual psychotherapy, marital therapy, pastoral counselling, medication, and group therapy. Three-years post effect was assessed in *N*=33 participants (Rosik, 2011, p. 175). This study found those who had engaged in treatment for more than six-weeks sustained their improvements. Those who had engaged for less than six-weeks saw a reduction by over a half of their initial improvement. On follow up 32 participants were engaging in continued additional treatment or therapeutic activities. Hinderances to continued improvement on follow up included lack of engagement from spouses and lack of care and support from 'sending organisations' (p. 179).
Strengths	The intervention used a range of professionals with ministry and missionary experience, and support from current serving clergy, offering a well-rounded psychological intervention. The study is culturally aware incorporating reading material, and videos aimed at a Christian audience, alongside prayer and bible reading. This aims to enhance "…psychological

	concepts such as boundaries and recovery with religious insights derived from the typical participants' faith system" (p. 690). The program is also open to couples and families, recognising the importance of community and family support. To avoid violations of independent assumptions from married couples, calculations were carried out by randomly eliminating one spouse from each pair (p. 693).
Limitations	The article states that nearly all participants were missing some data, either pre or post scores. Their missing scores were estimated by calculating the average (p. 693). The use of the Outcome Questionnaire-45 appears slightly problematic when considering if changes are clinically significant. Some participants entered the program with scores below the clinical threshold for distress, and so no clinically significant change was observed. Yet on follow up 87% of participants experienced some improvement. This measure alone provides an insufficient descriptor of intervention success.
Number	14
Author, year, publication type, location	Scott and Lovell (2015) journal, USA.
Participants, and sample sex	*N*=34 mixed sex, denominations not stated.
Study design	'The Rural Pastors Initiative' – An 18-month intervention, including a mixture of a week-long 'Summer Intensive' and regional 'Area Gatherings' at five points, with virtual support in-between. The initiative focused primarily on psychological factors "including loneliness, isolation, burnout, an imbalance between personal and professional life, and an absence of self-care activities" (p. 71). Two goals were defined as, "(1) foster excellence and "professionalism" in pastoral leadership and ministry in contemporary rural settings, and (2) promote long-term personal well-being and satisfaction in rural ministry" (p. 74). Clergy participated in education, small group work, and reflection on their progress at regular intervals.
Main findings	Clergy in this study experienced a significant degree of loneliness and isolation (p. 71). Loneliness was a statistically significant predictor of other factors such as burnout and professional excellence (p. 71). Notably, the intervention did not

	result in any meaningful change in self-care engagement. The article does not describe the intervention in detail or what particular areas of teaching or support proved useful.
Strengths	The study was useful as a profile of the psychological states and negative factors rural pastors experience. The study identified factors that may be addressed in future interventions. The study also contained notable findings on female pastors such as struggles with privacy and gender norms.
Limitations	Clergy were personally known to the research team, and as such those clergy may have already been motivated to engage or change health behaviours, possibly skewing results (p. 76). The sample did show substantial participant attrition, rationales for this were briefly touched on however, some stated that the program 'did not meet their needs' (p. 77). A deeper understanding and exploration of this shortfall may help shape future interventions.
Number	15
Author, year, publication type, location	Smith (2015) thesis, USA.
Participants, and sample sex	*N*=8 UMC clergy, mixed sex.
Study design	Three-month holistic intervention with "five bi-monthly meetings and a two-day retreat (half-way through) which integrated peer support, focused lessons, and reading materials" (p. i). The project emulated 'Spirited Life' and followed a format of education, self-reflection, and partner discussion. Discussions and reflections were formed around Hooten's (2011) definition of holistic health in the place of ministry. Due to time constraints, the set curriculum was not completed in the sessions, and as such, bible study homework was set.
Main findings	Participants found the sessions beneficial, making individual intentional holistic changes. Although the thesis does not strategically categorise feedback, positive comments are included around the motivators. Some participants were

	expecting more health coaching with "weight or fitness goals" (p. 57). Participants did value sharing with clergy who they do not usually meet with, reducing their anxiety. Upon reflecting on their original calling, some stated they felt called to be healers, teachers, administers of the sacrament, yet the demands of the role diluted their original calling.
Strengths	The intervention had a theological underpinning by assigning reflection on Jesus' ministry and rest rhythms between sessions. It also used key biblical texts and prominent Christian authors to support holism. The group also spent time praying for each other around the intervention's themes. One participant stated "...without the spiritual and theological grounding we have developed we cannot maintain our health. We have learned that health is not another "to-do" list but rather the very essence of who we are and how we do ministry" (p. 59).
Limitations	The five sessions plus the retreat were a significant time commitment. The text states dozens of clergy expressed interest in holistic health improvement, however, due to busy schedules and demands they were unable to participate. The main findings of the project are hard to discern. The thesis is reflective and does not appear to present findings as expected in a published peer-reviewed article.
Number	16
Author, year, publication type, location	Soto (2015) thesis, USA.
Participants, and sample sex	*N*=3 Latino Pentecostal clergy across three churches (two in Florida, one in North Carolina). Unknown sex.
Study design	Six-month intervention using existing teambuilding model 'Spiritual Leadership, Inc.' aimed at reducing burnout rates in clergy. "Teams working under the SLI model learn to love each other by building and living in covenantal relationships and holding each other accountable" (p. 82). The intervention sought after "…(1) developing spiritual leaders, (2) creating environments of transformation, and (3) developing processes/systems that produce fruit" (p. 82). An instructional meeting with participants and their teams was held pre and post-intervention. Each participant selected a small team from their own church to meet with once per week for two-hours to discuss their 'ministry action plan'. This

	action plan uses themes similar to SMART goals "…values, mission, context, strategies, vision, measurement indicators, accountable individuals, and due dates for strategies" (p. 83). Burnout was measured pre-intervention and post-intervention. Qualitative data on the effectiveness of the intervention was captured using post-intervention one to one interviews and a focus group.
Main findings	Burnout score, pre to post-intervention, showed a substantial reduction across the emotional exhaustion and depersonalisation sub-scales. Scores for personal accomplishment increased across the group by 26%. Despite reductions in burnout scores, stress self-report levels remained high. Qualitative data showed improvements in team functioning and professional relationships. Clergy also noted improvements in their ability to deal with professional concerns.
Strengths	The author requested that participants sign a 'covenant', to assure their full engagement for the duration of the intervention (p. 7) using religious accountability. Despite a shortened version of the full program being offered, some moderate benefits in team functioning and burnout were seen in the six-month period. These data may offer a foundation for piloting a shortened version of the program.
Limitations	All pastors included were bi-vocational, having full-time jobs in addition to ministry (p. 86). A larger sample size with a mix of vocational statuses would be advantageous to explore the interventions effectiveness more closely. The 'Spiritual Leadership, Inc.' program is designed to run for 18-months. Effect after six-months may be underestimated. No explanation of the reduced runtime was offered. The small sample size limits the assumptions that can be drawn from the results. The methodology of the intervention, what the clergy did in the two-hour meetings, and what was discussed pre and post-intervention, is unclear.
Number	17
Author, year, publication type, location	VanLoon (2009) journal, USA.

Participants, and sample sex	*N*=32 (*n*=17 intervention group, *n*=15 control group). Mixed sex. Eleven unspecified denominations included.
Study design	Four 1.5-hour sessions exploring hypothetical congregant situations and clergy's response in forgiveness, aiming to improve psychological wellbeing in the areas of "…self-esteem, anger, anxiety, willingness to forgive" (p. 2). Data was collected across four domains using a range of inventories. The decision to forgive section was explored using a combination of teaching, "…group discussions, personal journal reflections…" (p. 4) and application of theory to the hypothetical scenarios.
Main findings	Data showed a statistically significant increase in participants' willingness to forgive (compared to the control group). Participants were able to apply learned strategies to the hypothetical situations and recommend forgiveness strategies to congregants.
Strengths	This study adds to the small volume of work on forgiveness and faith-based organisations, where forgiveness literacy is sometimes assumed (p. 3). The work showed cultural competence with the inclusion of a forgiveness covenant at the end of the intervention.
Limitations	Denominations were not specified, ergo denomination specific positive results could not be explored. The methods and session content were not detailed, and it is unclear how each session was run. Other than the incorporation of the four phases of forgiveness, it is not clear what was taught in each session.
Number	18
Author, year, publication type, location	Webb and Bopp (2017) journal, USA.
Participants, and sample sex	N=44 (*n*=24 invention group, *n*=20 control group) denominations, not specified. Mixed sex.

Study design	'Walking in Faith' – A 12-week internet mediated (Moodle) program seeking to improve physical activity engagement in clergy who were classified as sedentary or insufficiently active. Base-line and follow-up activity levels were determined over seven days by accelerometer (ActiGraph GTX3+). Various perception scales were used to determine participants' motivation, confidence, perceived benefits, and support. All participants received a $10 gift certificate.
Main findings	Compared to the control group, the intervention group showed statistically significant improvements in sedentary time, behaviour, physical activity engagement at the moderate level (as measured by accelerometer) and motivation (p. 569).
Strengths	Each topic during the 12-week period was linked to a biblical text providing a theological imperative, showing cultural sensitivity. The web-mediated design allowed for engagement at a self-selected convenient time. The use of self-report and accelerometer data allowed for some clarification on activity levels where it is believed some may under or over-report levels.
Limitations	Self-report data was relied upon for BMI calculation. Not all participants completed the 12 lessons, however, results indicate that this did not affect results (those completing six or 12 showing similar results). Core content was included in the first six lessons, indicating that the study design could be shortened to improve engagement. Forty-three different faith-based organisations were included. The study cites this as a potential limitation in not allowing for the exploration of the positive effects of social support within a single organisation. Some sedentary time may have been "misclassified" as non-wear time due to user error in the accelerometer (p. 572).

5.7 Critical Examination and Emergent Themes

Having analysed the items and charted their key characteristics, emergent themes were categorised as follows:

5.7.1 Country of Origin

All interventions included in this review took place in the USA across 15 different states, with no obvious pattern. One nationwide intervention was included.

5.7.2 Report Year

The interventions included in this review were reported between 2007 and 2021. Nine of the interventions were reported on between 2015 and 2016. Three were reported on in the last three years.

5.7.3 Sample Sizes

The range of sample sizes across the reviewed interventions can be viewed in Table 32. Sample sizes ranged from one pastor and his wife (Abernathy et al., 2016) to 1,114 clergy participants (Proeschold-Bell et al., 2017). Conversely, some researchers such as Davis (2010) achieved much smaller than expected sample sizes. Smith (2015) found similar difficulty, stating many clergy were interested in an intervention, yet due to the demands of the role, they were unable to participate. It is not clear why, given the two-year time commitment in Proeschold-Bell et al.'s (2017) work, this attracted so many committed participants. Yet, when considering other authors like Smith (2015) who modelled their work on Proeschold-Bell et al.'s (2017) study, they struggled to recruit and maintain clergy.

Table 32
Number of Participants Included in Each Intervention

Author	Number of participants
Abernathy et al. (2016)	1 pastor and his wife
Cuthbert et al. (2018)	71
Cutts et al. (2011)	No total sample size figures provided (10 – 12 participants in groups)
Davis (2010)	7
Emmons (2015)	10
Jensma (2016)	191
Kanipe (2016)	13
Leach (2018)	6
Muse et al. (2016)	23
Muse (2007)	Not given, author cites over 10 years of research.
Park (2021)	15
Proeschold-Bell et al. (2017)	1,114
Rosik et al. (2009)	142
Rosik (2011) (follow-up study)	33
Scott and Lovell (2015)	34
Smith (2015)	8
Soto (2015)	3
VanLoon (2009)	32
Webb and Bopp (2016)	44

5.7.4 Length of Intervention

Lengths of the interventions varied greatly from two-hours teaching time (Park, 2021) to three-years (Abernathy et al., 2016) (Table 33). Some of the longer interventions incorporated a more intensive residential retreat at one or more time points during the intervention. The longer interventions required participation

throughout (e.g., with health modification i.e., nutrition or exercise) however, they did not require the researcher to maintain persistent contact throughout. In this case, researchers checked in and logged progress at designated time points e.g., Abernathy et al. (2016) Emmons (2015) and Proeschold-Bell et al. (2017).

Table 33
Length of Each Intervention

Author	Length of intervention
Abernathy et al. (2016)	3 years
Cuthbert et al. (2018)	16 days
Cutts et al. (2011)	2 days
Davis (2010)	8 weeks
Emmons (2015)	6 months
Jensma (2016)	3 weeks
Kanipe (2016)	10 weeks
Leach (2018)	1.5 days
Muse et al. (2016)	1 week
Muse (2007)	1 week
Park (2021)	2 hours teaching with one-to-one follow up.
Proeschold-Bell et al. (2017)	2 years
Rosik et al. (2009)	Total time is unclear. Between 10 – 15 hours
Scott and Lovell (2015)	18 months
Smith (2015)	3 months
Soto (2015)	6 months
VanLoon (2009)	6 hours
Webb and Bopp (2016)	12 weeks

5.7.5 Denominations Featured

The denominations investigated varied, however, UMC clergy featured prominently. Baptists were featured in four interventions (Abernathy et al., 2016;

Kanipe, 2016; Leach, 2018; Muse et al., 2016). Those interventions which sought to provide emergency restorative support (e.g., Muse et al. [2016]) included a wider range of denominations. Some featured an unusual mix of denomination numbers, for example, Kanipe (2016) who included 12 UMC clergy and one Southern Baptist, and Muse et al. (2016) who included one Baptist, two Lutherans, and one Episcopalian.

5.7.6 Use of Religious / Biblical Prompts and Cultural Competence

Sixteen of the interventions used overtly Christian themes and activities in their interventions. These ranged from biblical scriptural examples of health and wellbeing from the apostles and Jesus, to prayer, spiritually sensitive material, accountability and participant covenants, alongside staff and researchers with religious or ministry experience delivering intervention components. Participants positively commented on the intervention's scriptural or spiritual content, providing a theological health behaviour driver. Most notably, Emmons (2015) drew on his personal experience as a pastor with lived experience of significant weight loss, four of the 10 case studies cited this as a significant motivator for their personal health changes. Scott (2015, p. 59) captured the essence and necessity of theological and spiritual components in one participants' comment: "...without the spiritual and theological grounding we have developed we cannot maintain our health. We have learned that health is not another "to-do" list but rather the very essence of who we are and how we do ministry".

5.7.7 Individual Reflection

All items used a form of personal reflection in the intervention, variations can be observed in Table 34. Some form of personal, group, or guided reflection appeared integral to all the intervention designs.

Table 34
Modes of Reflection Included in Each Intervention

Author	Mode of reflection
Abernathy et al. (2016)	Meditation
Cuthbert et al. (2018)	Workbook
Cutts et al. (2011)	Meditation, books, and CDs
Davis (2010)	Daily reflective homework
Emmons (2015)	Coaching and onsite (e.g., supermarket) contemplation of actions (e.g., food choices)
Jensma (2016)	Psychotherapy
Kanipe (2016)	Recorded sabbath practice
Leach (2018)	Coached self-reflection
Muse et al. (2016)	Psychotherapy
Muse (2007)	Psychotherapy
Park (2021)	Journaling
Proeschold-Bell et al. (2017)	Coached self-reflection
Rosik et al. (2009)	Psychotherapy
Scott and Lovell (2015)	Small group and individual reflection on progress
Smith (2015)	Self-reflection and partner discussion on select topics
Soto (2015)	Creating a ministry action plan
VanLoon (2009)	Journaling
Webb and Bopp (2016)	Reflecting on biblical examples

5.7.8 Group Work

Thirteen of the items clearly state the use of some form of group work. This ranged from formal group therapy (Jensma, 2016) to informal sharing and support on Facebook (Emmons, 2015). Group work appeared to be a key factor to many of the interventions, with some participants clearly citing the personal benefits of this element (Abernathy et al., 2016; Leach, 2018). Abernathy et al. (2016, p. 183) stated of their participants: “They were thankful for a safe space for this kind of intimacy. Being with others who had similar struggles and having the opportunity to share with the group made them feel less alone”.

5.7.9 Teaching and / or Coaching

All interventions featured some form of teaching or coaching. Approaches varied including formalised psychotherapy (Rosik et al., 2009) one to one coaching on specific health facets (Emmons, 2015) internet mediated taught sessions (Webb & Bopp, 2017) workbook activities (Cuthbert et al., 2018) student designed and led teaching sessions (Park, 2021) or a mixture of approaches including tele-health coaching in between formal residentials (Proeschold-Bell et al., 2017).

5.7.10 Targeted Health Facets

The targeted health facets in each intervention can be observed in Table 35. Notably, only four interventions had a holistic focus; Proeschold-Bell et al. (2017), their colleagues Cutts et al. (2011) Leach (2018) who was advised by Cutts, and Smith (2015) who emulated Proeschold-Bell et al.’s (2017) work.

Table 35
Health Facet/s Targeted in Each Intervention

Author	Targeted health facet/s
Abernathy et al. (2016)	Mental (psychological resilience post-trauma)
Cuthbert et al. (2018)	Mental (positive psychology intervention)
Cutts et al. (2011)	Holistic (physical, mental, spiritual)
Davis (2010)	Mental (mindfulness-based stress reduction)
Emmons (2015)	Physical
Jensma (2016)	Mental
Kanipe (2016)	Physical and mental (sabbath rest)
Leach (2018)	Holistic (physical, mental, spiritual)
Muse et al. (2016)	Mental
Muse (2007)	Mental
Park (2021)	Mental (anger management program)
Proeschold-Bell et al. (2017)	Holistic (physical, mental, spiritual)
Rosik et al. (2009)	Mental
Scott and Lovell (2015)	Mental with occupational elements
Smith (2015)	Holistic (physical, mental, spiritual)
Soto (2015)	Occupational (burnout and team-working)
VanLoon (2009)	Mental (self-esteem, anger, anxiety, and forgiveness elements)
Webb and Bopp (2016)	Physical

5.7.11 Incorporation of Retreats

Eleven of the interventions featured some form of intensive or retreat (Table 36) ranging from half a day to three weeks on weekdays. Four items featured a retreat as part of a longer intervention format. These retreats were mixed with other contact, coaching, and participant driven activities (e.g., Abernathy et al. [2016] and Proeschold-Bell et al. [2017]). Notably, Proeschold-Bell et al. (2013a) discuss the beneficial nature of retreat interventions that allow clergy uninterrupted time to focus

on wellbeing factors. They do however suggest some potential limitations: "…this format does not enable clergy to learn how to integrate health behaviors into their daily lives, and it can be difficult for pastors to take time away from their responsibilities at their parishes" (Proeschold-Bell et al., 2013a, p. 140).

Table 36
Inclusion of Retreats

Author	Retreats - Yes (Y) or No (N)
Abernathy et al. (2016)	Y three annual meetings over three years, lasting three days each
Cuthbert et al. (2018)	N
Cutts et al. (2011)	Y two days
Davis (2010)	N
Emmons (2015)	N
Jensma (2016)	Y three weeks (weekdays only)
Kanipe (2016)	Y one day
Leach (2018)	Y one and a half day
Muse et al. (2016)	Y one week (outpatient)
Muse (2007)	Y one week residential
Park (2021)	N
Proeschold-Bell et al. (2017)	Y three retreats over two years, an initial three-day, two-day mid and end point
Rosik et al. (2009)	Y intensive outpatient treatment 10 – 15 hours.
Scott and Lovell (2015)	Y five points over 18-months, a weeklong intensive, and four regional gatherings (unknown length)
Smith (2015)	Y two-day retreat at the halfway point of the three month intervention
Soto (2015)	N
VanLoon (2009)	N
Webb and Bopp (2016)	N

5.7.12 Methodological Strengths and Limitations

Methodologies and approaches varied greatly across the interventions. Some took a primarily spiritual / theological approach, whereas others used a mix of medical and religious specialities, approaches, and expertise. This variation may be due to the origin of the intervention and the researcher's personal speciality. Many of the theses, for example, were undertaken as part of a Doctor of Ministry program, where student researchers approached projects from a primarily spiritual and religious occupational vantage point.

A lack of this multidisciplinary collaboration can be seen in Park's (2021) work. This thesis takes a primarily spiritual approach to anger management. It identified a participant who had experienced sexual abuse, suicidal ideation and behaviour, and may have been experiencing ongoing mental health and wellbeing issues. The 'deliverance' approach the researcher took in managing this disclosure (although common in some spiritual circles) could be viewed as unethical, and potentially damaging to the participant's ongoing mental health journey. This work presents an argument for the necessity, in some interventions, for methodologies that include mixed professionals or expertise, and an awareness of the holistic nature of health.

Conversely, some of the more holistic interventions sought to collaborate and use a range of professional expertise to map, educate, and improve clergy wellbeing (e.g., Cutts et al. [2011] Kanipe [2016] Leach [2018] and Proeschold-Bell et al. [2017]). Some, additionally, used a longer multipoint intervention strategy to promote sustainability in real-world ministry settings (e.g., Abernathy et al. [2016] and Proeschold-Bell et al. [2017]). Indeed Proeschold-Bell et al. (2013a, p. 141) highlight the importance of the length of participant engagement in real world

research where life factors (such as stress) may impact the target variable (such as weight management). They state, “An intervention that successfully sustains weight loss may need to be long enough for participants to cycle through high- and low-stress periods and practice adaptive stress responses” (Proeschold-Bell et al., 2013a, p. 141).

All of the interventions generated new data. Data were collected using a mixture of qualitative and quantitative methods, standardised questionnaire tools, self-reports, and interviews. Most notably, in Cuthbert et al.’s (2018) intervention, statistical analysis of measures of life satisfactions and humility showed no significant change. Yet, in self-report data and personal reflections, participants indicated that their personal relational humility had increased. This study indicates some benefit to collecting data using different methods in this newer research area of clergy interventions. Self-report data, although subjective, may help shape future intervention methodology with regards to what personally resonated with some clergy. Emmons (2015) for example, also presented numerical change data (e.g., weight) alongside personal reflections from clergy participants. Here, reflective data pointed towards the usefulness of personal stories of weight loss transformation from the student researcher. These data may help shape future interventions and may have been lost if statistical analysis alone was relied upon to quantify intervention success.

5.7.13 Intervention Outcomes

Of the interventions which presented findings, all showed some positive effects either statistically or in participant reflections. Emmons (2015) for example, noted profound participant weight loss (between 42 – 90 pounds) and adjacent positive improvements in fitness level, personal relationships, and ministry. Some

studies found a mixture of positive behaviour change and little or no effect in other target areas. Davis (2010) for example, found a reduction in negative emotional patterns and depressive symptoms, however, little difference in anxiety levels.

As a significant proportion of the interventions were theses, this presented a finite time limit on the interventions, and as such, long term sustainability of any positive change could not be determined. These snapshot interventions suggest the necessity for longitudinal studies to support and measure sustainable positive health change.

Most notably, Cuthbert et al. (2018) take a balanced and objective approach to their intervention result reporting, which showed no statistically significant effects. They quote Boiler et al. (2013, p. 17) who support the reporting of findings even when a lack of statistical significance is found, to attempt to reduce publication bias. This open approach may support future intervention development and direction.

5.8 Discussion

The aim of this systematised review was to explore existing clergy health interventions and identify key characteristics of successful works to inform a feasibility and acceptability intervention for UK Baptist clergy. This review provided analysis of 18 interventions (11 journals and seven theses) that aimed to promote positive health behaviour change in clergy. Although this review did identify some prominent characteristics, no clear format or gold standard was identified.

No previous reviews were identified in the process of the current review. The foundational work of Proeschold-Bell et al.'s (2017) two-year Spirited Life intervention (entry 12) does somewhat mirror the results of the current review. Although few published works were identified, the team did uncover a number of

unpublished US denomination specific interventions, intervention specifics however, (the exact steps, processes, results and data) were not publicly available (Wallace et al., 2012). The team identified such activities by Google searching and contacting individual program staff, however, this proved unsuccessful for identifying programs and program components (Wallace et al., 2012). Additionally, this team's search highlights the lack of communication between differing Protestant denominations, the academic community, and indeed intra-denominationally. In their conclusion, Wallace et al. (2012, p. 122) point toward the lack of gold standard clergy intervention criteria, research dissemination, and communication: "…it appears that they are working in isolation from one another and that there is no central source to learn about different kinds of clergy health programs. Currently, evaluation and dissemination are lacking for clergy health programs." Notably these findings mirror the seemingly poor communication, collaboration, and dissemination of work, data, and recommendations from the Church of England as discussed in Chapter two. The conclusions drawn from Wallace et al.'s (2012) work, in addition to this review's findings, point toward the need for further exploratory and feasibility work in the field of clergy health interventions. At best, the key characteristics identified in the current review may be used as a foundation to intervention building, an adaptive preliminary step prior to any future full-scale interventions.

Intervention results all show positive behaviour change in all or part of the target variable (and some adjacent health facets) through the approaches taken. Prominent characteristics emerged, including group work, spirituality practices / theological grounding, taught components, personal reflection, and holism. It is evident therefore, that using the strategies adopted in these interventions may be beneficial in future interventions. Ultimately, this review highlights the lack of

clergy health intervention work in the UK (and internationally) in any denomination. Additionally, improvements could be made with reporting and results translation.

5.8.1 Future Recommendations

This systematised review has highlighted some recommendations for future interventions:

- It is evident from the works presented in this review, that there is a need for UK and other international published works outside the US.
- Interventions would benefit from longitudinal approaches, allowing participants time to integrate positive health behaviours into their real-world ministry practice, whilst evidencing sustainability.
- Interventions should ideally take a multi-professional (or mixed experience / speciality) approach that allows for safe, balanced holistic health interventions.
- Communication, dissemination, and collaboration methods need to be improved intra and interdenominationally and with the wider academic community. This approach may highlight best practice and avoid unnecessary repetition.
- Clergy interventions clearly benefit from peer collaboration (e.g., group work) and religious, spiritual, and theological underpinning.
- As clergy health interventions are a contemporary area of research, a mixed methods approach would be advantageous.
- Due to the known interrelationship between human health facets, it would be advantageous to approach interventions from a holistic standpoint.

5.8.2 Implications for a Feasibility Intervention

This review has emphasised some popular and effective components to carry forward to stage four's feasibility and acceptability intervention. As with some of the other theses included in this review, certain time and resource restrictions apply which may limit the inclusion of select elements. Using this review as a foundational framework, it would be advantageous to include the following elements:

- Teaching – A taught section, aiming to improve clergy knowledge on some areas of holistic health.
- Holism – Any sections should consider the holistic interlinking nature of human health and wellbeing.
- Group work – Peer support where clergy may encourage, share, and emotionally strengthen one another in their challenges and goals.
- Spiritual and theological components – Key biblical references should be included to demonstrate a theological foundation and imperative. As is common in Christian meetings, participants should be invited to participate in an opening and closing prayer through personal silent reflection.
- Personal reflection – Uninterrupted time to personally reflect on individually identified areas of personal health and wellbeing challenge.
- Multidisciplinary participation – Value can be drawn from a team of multidisciplinary professionals supporting an intervention. Although resources do not allow for this in this thesis, suitable skill, knowledge, and safety can be assumed from the student researcher's credentials.

The student researcher is an NMC registered nurse, professional member of the International Stress Management Association, Mental Health First Aid Instructor Member, workplace health and wellbeing specialist, Fellow of Advance HE (British higher education growth, support, and development organisation [Advance HE, n.d.]) university level Associate Lecturer, National trainer, and committed Christian.

- Sample size – Any sample size in stage four's intervention will provide a valuable contribution to the scant UK clergy research pool.
- Denomination – Although some interventions include members from various denominations, stage four will focus on the Baptist denomination. This aims to provide a clear understanding of the suitability of this type of intervention for this specific cohort.
- Reporting – Clear reporting on all the steps taken and session processes is essential, as this allows for duplication or modification in larger iterations or in other denominations.

5.8.3 Limitations of this Systematised Review

Systematised reviews may present certain limitations such as the potential for review bias (e.g., with selection, final screening, analysis, and coding) (Barr-Walker, 2017; Grant & Booth, 2009). An attempt in this review, was made to somewhat mitigate this bias by discussion with the thesis supervisor and a critical friend.

This review used a reductive search process based on the author's subject knowledge and the specialist research librarian's experience of search terms. It is understood, however, despite attempting an exhaustive search methodology, that not

all eligible clergy interventions were identified. Additionally, due to the known limitations in some denominations' practices regarding result reporting, it is possible this review may not represent contemporary initiatives that are not publicly available.

Strict review protocol, as expected in a systematic review has not been adhered to, however, the principles and procedures carried out in this review, are clear, logical, evidenced based and duplicatable. This 'modelling' of the systematic review process is deemed appropriate for the systematised approach (Grant & Booth, 2009, p. 13).

5.8.4 2024 Update

Since this review was conducted on 6th April 2021, with the search year parameters of 2001 – 2021, no clergy holistic health interventions have been conducted in the UK. This lack of recent UK works further highlights the novel contribution and relevance of the intervention detailed in Chapter six.

One further international intervention and one pilot study have been identified since this review was conducted. These items feature the same authors included in this systematised review, Proeschold-Bell and Webb (Proeschold-Bell et al., 2023; Harmon et al, 2023).

The work featuring Proeschold-Bell, a pilot study 'Selah', attempted to address anxiety and occupational stress (Proeschold-Bell et al., 2023) a facet in their original two-year study that showed no statistically significant improvement (Proeschold-Bell et al., 2017). This intervention recruited a convenience sample in the same North Carolina UMC Methodist region and used a combination of training, mindfulness, centring prayer and daily Examen a form of prayer from the Jesuit

tradition (Proeschold-Bell et al., 2023, p. 2690). The results of this intervention indicated that all portions, except the centring prayer, may positively affect stress and anxiety levels at the 12-week mark as shown across their chosen stress and anxiety scales and biometric data (Proeschold-Bell et al., 2023). Although the study provides outcome data, it does state that as a pilot the purpose of the study was to assess suitability, results are therefore indicative and do not provide definitive data on effectiveness. The main difference between this pilot and their previous two-year intervention appears to be the intensity and variety of activities in the intervention. This pilot appeared significantly more comprehensive in addressing stress in a multifactorial way through training and personal practice. Their original study appeared limited in offering one workshop (or online stress management program for those waitlisted [Proeschold-Bell et al., 2017]) potentially highlighting why this pilot indicates greater stress reduction over their original two-year study.

The second intervention featuring author Webb was the ‘Fit with Faith’ 10-week intervention, targeting diet, physical activity and stress (Harmon et al., 2023). This intervention featured twenty African American clergy and their spouses, no specific denominations were cited (Harmon et al., 2023). Results showed statistically significant improvements in biometric data and self-regulation scores, yet positive changes appeared limited to females and younger participants (Harmon et al., 2023, p. 2627). Similar to Webb’s earlier work (Webb & Bopp, 2017) this intervention relied heavily on technological administration, although the current intervention did incorporate face to face components. Notably, the interventions results report that clergy in this group appeared more engaged with the face to face and telephone components than daily app tracking. This intervention although limited suggests the

potential necessity for variation in progress tracking and engagement methods to suit different personal preference and age groups.

These two additional items, and the lack of any UK works, further reinforce the necessity for UK clergy health and wellbeing interventions. The items indicate the potential effectiveness of well-structured holistic programs, and the necessity for piloting, acceptability and feasibility testing and adaption to ensure appropriate fit across the cohort.

5.9 Chapter Conclusion

This chapter has presented the results of a single student researcher led systematised review which identified 18 clergy health interventions targeting a single or multiple health facets. Seven of the items were theses, and all of the works were US based. This review identified the prominent beneficial characteristics of the interventions, which included a blended intervention approach including taught or coached sections, some personal reflective activities, group or partner work and support, and a strong theological foundation. Additionally, this review has identified several areas for consideration in future research, including longitudinal approaches, multidisciplinary involvement, improved academic and professional communication of results and processes, and holistic and mixed methods approaches.

All interventions presented some positive behaviour change. This further presents an argument for the purpose and contemporary necessity for clergy health interventions. Clergy, as shown in previous chapters, experience some health inequalities against comparative populations. Ergo, more UK denomination specific health profiling, investigations, and as shown from this review, interventions are

needed to create a rich evidenced based foundation for contemporary occupational recommendations.

Chapter 6: The Acceptability and Feasibility of an Intervention to Support Self-care in Baptist Church Clergy.

6.1 Introduction

Informed by this thesis' previous investigations, this chapter presents the procedure and findings from a bespoke clergy feasibility intervention to promote self-care. UK Baptist clergy were invited to take part in a 90-minute online participatory group intervention hosted on MS Teams. The intervention comprised three distinct sections (teaching, self-reflection, and group discussion), was proceeded by a pre-intervention survey, and concluded with post-intervention survey. The identical intervention was delivered to 11 participants in three groups. Groups were determined by participants' choice of a convenient session time and date slot. The same intervention was offered at four different date and time slots across July, August, and September 2022, however, only three sessions were filled. This intervention presented some positives and negatives if developed and rolled out across the Baptist network. Participants voiced that they wanted larger groups, and more interaction from others to discuss and share challenges and strategies for better self-care. Notably, all participants saw value in some or all aspects of the session, with many voicing that this would be a useful opportunity for all BUGB clergy.

6.2 Background

It became evident from both the quantitative and qualitative portions of this thesis that the cohorts under investigation presented with varying biopsychosocial issues, with no two participants being the same. Targeting multiple holistic health facets within one intervention therefore, required a strategic, pedologically sound approach, carefully selected and informed by current literature and other disciplines.

6.3 Research Impact

Since the 2006 governmental push to manage, assess, and restrict research funding based on its societal impact (Research Excellence Framework [REF], 2014a) detailing 'research impact' has become an increasingly important project consideration. Impact is defined as "…any effect on, change or benefit to the economy, society, culture, public policy or services, health, the environment or quality of life, beyond academia" (REF, 2014b, p. 4). A primary impact of the current intervention will be as a valuable academic addition to the research field. Study results may be used to inform larger scale interventions which may impact the wider field of Baptist clergy. Research impact, even if limited to an addition to a limited academic field, is an important consideration (Taylor & Francis Group, n.d.).

6.4 The Place and Purpose of Feasibility Interventions

Feasibility studies are a valuable step in intervention planning prior to full scale roll out (Van Teijlingen & Hundley, 2001). There is division regarding the components of a feasibility study versus a pilot study, with some authors using the terms interchangeably (Thabane et al., 2010; Van Teijlingen & Hundley, 2001) and others citing distinct differences (Arain et al., 2010; Donald, 2018). For the purposes of this investigation, the term 'feasibility study' will be used. Pilot studies are accepted as small-scale versions of an intended larger roll out and test if all the devised components will run smoothly and as intended or expected (National Institute for Health and Care Research, 2019). Whereas some believe feasibility studies are independent research pieces intended to plot out the accepted parameters, test portions, and make edits for a larger scale study (Arain et al., 2010; Donald, 2018; National Institute for Health and Care Research, 2019; Tickle-Degnen, 2013).

Feasibility studies according to Bowen et al. (2009, p. 453) "…enable researchers to assess whether or not the ideas and findings can be shaped to be relevant and sustainable". Acceptability and feasibility of the key intervention components is a primary goal of this investigation, as it is not known if the applied components, mainly drawn from US research, are acceptable to a UK cohort. It is accepted that edits may be required by future researchers, followed by piloting prior to full-scale roll out.

6.5 Research Question and Logic Model

The following research question was explored:

- What is the acceptability and feasibility of a tailored intervention to support self-care in Baptist church clergy?

  This efficacy of this intervention as per the research question will be evaluated using Gadke et al.'s (2021) 10 assessment criteria (see analytical approach).

Figure 8
Intervention Logic Model

Rationale – This thesis' previous studies and the international literature indicate health deficits in clergy. There is no available UK clergy self-care intervention research, to date. This intervention, therefore, sought to assess the feasibility and acceptability of a tailored self-care intervention for UK Baptist clergy.

Inputs	**Activities**	**Outcomes**
• Time – session delivery and design • Time – participant • Time – gate keepers e.g. BUGB assisting with advertising • Technology both for delivery and participation • Suitable number of participants per group to promote conversation and skill sharing	• Promoting the intervention • Recruiting participants and assigning them to balanced groups • Delivering the session • Collecting, organising, and analysing pre and post-intervention data • Reporting / disseminating results	**Immediate** • Increased knowledge of the interrelationship of health facets and holistic health • Increased personal self-care motivation • Personal self-care reflection **Medium term** Personal health benefits, e.g., weight loss, improved relationships, reduced stress etc. **Long term** • Culture, systems change (increased personal, church level and organisational focus on self-care) • Clinical outcomes – measurable health benefits e.g., decreased BMI, improved mental wellbeing etc. • Personal perceived health benefits – the participant feels more energised, sociable, mentally well etc. • Improvements in job efficacy

Assumptions - clergy will have time to attend, clergy will be open to the message of change, clergy will want to attend, that the chosen activities and methods are effective at promoting health behaviour change, clergy will want to discuss self-care with peers.

Note - Logic model produced as per the Midlands and Lancashire Commissioning Support Unit (2016) and Moore et al.'s (2015) guidelines widely used in public health research and interventions.

6.6 Ethical Considerations

6.6.1 Institutional Approval

Ethical approval for this study was granted on the 10th June 2022 by the University of Nottingham, faculty of Medicine and Health Sciences (reference DPAP - 2022 - 2849 – 3) (Appendix P).

6.6.2 Consent

Participants were required to complete two surveys during the study (before and after the intervention) and consent for all sections was obtained at the start of the first survey. Participants could not proceed through the first survey without acknowledging nine standardised consent questions approved by the University of Nottingham, faculty of Medicine and Health Sciences ethics committee. These questions confirmed the participants age, awareness of where to seek support if they had questions relating to the study, alongside confirming they had read and understood the study outline, procedure, expectations, the voluntary nature of the study, right to withdraw, and that anonymised quotes from the final survey may be used and shared in written summary reports.

6.6.3 Risk of Coercion

To avoid any undue pressure or latent coercion, advertising materials were worded neutrally, in that no standard of health was implied or required to participate, the intervention sought individuals' personal views and opinions only. Generic flyers (Appendix Q) were designed and distributed via social media and through links with the BUGB. The wording and imagery selected was clear, concise, informal, and non-

judgemental. It was clear in email and social media advertising that participation was voluntary.

6.6.4 Confidentiality and Anonymity

6.6.4.1 Pre and Post-intervention surveys.

No person identifiable data was collected in the pre and post surveys. Pre and post answers were linked using a unique identifier produced by each participant consisting of the last three numbers and letters of their postcode and the last three numbers of their phone number (see survey page two, Appendix M). Data collected in these surveys was housed on the secure survey platform Online Surveys (Online Surveys, n.d.).

6.6.4.2 During the Intervention.

Participants were reminded at the start of the session not to share anything confidential or anything that they would object to being shared in subsequent research outputs. Participants were encouraged to protect their own wellbeing and only share content as they saw fit. At booking, participants were assigned a number for the group work activity. This number denoted a column on Padlet where participants could share thoughts anonymously and other participants could offer anonymous encouragement, hints, and tips. Participants were discouraged from sharing person specific information during the session such as names, ages, years of service or locations. This aimed to protect anonymity alongside encouraging open discussion.

6.6.5 Further Support

Participants were provided with a list of support agencies at the end of the second survey. The contact details of agencies including Mind, Crossline, and the NHS website were provided should participants feel the need to discuss or explore any of the health and wellbeing matters raised in the intervention.

6.7 Method and Materials

6.7.1 Design Inspiration

The design of this intervention was inspired by three elements:

1) The practical procedure - The University of Nottingham's Researcher Academy (RA) Getting to Grips with Academic Writing online course (The University of Nottingham, n.d.-b).
2) The key components - The international literature as per the results of Chapter five.
3) Elements appealing to a UK audience – Qualitative responses by UK Baptist clergy collected in Chapter four's investigation.

6.7.1.1 Intervention Strategic Pedagogical Approach.

The author examined methodologies which may prove suitable for a small, single person led feasibility intervention. The author facilitated The University of Nottingham's RA Getting to Grips with Academic Writing online course (The University of Nottingham, n.d.-b). Elements of this course provided inspiration and practical tips on running an engaging and effective short course. Getting to Grips with Academic Writing (The University of Nottingham, n.d.-b) uses a hybrid of

contemporary learning approaches, the Charette process, problem-based learning, peer problem solving, and student-centred learning (Bodine et al., 2021; Webber, 2016). A key factor of the Charette process is collaborative problem-solving, incorporating learning from others' personal experience, life stage, and professional expertise. Problem-based learning seeks to solve complex problems (often real-world based) using reflective processes and knowledge acquisition either from formal or self-directed learning, and group work (Markham, 2011; Yew & Goh, 2016). Problem-based learning is shown to be highly effective for long term knowledge retention (Yew & Goh, 2016). Additionally, therapeutic peer problem solving (rooted in problem-based learning) is used in many arenas, from stress and mental health to diabetes treatment (Espedido et al., 2019; Giusto et al., 2023; Mulvaney, 2019). Student-centred learning, in which the Charette process, problem-based learning and peer problem solving all feature, is characterised by three essential factors. These are the interaction between participants, leading to the peer led problem solving alongside the group facilitation (Pazos et al., 2010). This pedological approach highlights the important function and level of interaction the group facilitator must take. Pazos et al. (2010, p. 192) suggest this role be of a guiding nature, allowing students the space to "wrestle" with the problems at hand, which promotes a deeper learning experience.

The RA course invites participants to reflect and identify their individual difficulties such as procrastination or lack of editing skills. These issues are collated into an anonymous Padlet (Padlet, 2021) prior to the live session. During the live session, participants use virtual breakout rooms to discuss their concerns with peers and the group facilitator. The group then joins together for a short period of learning

followed by a second breakout. Here, participants are invited to discuss solutions to the problems on the Padlet and add a solution pinned to the issue.

This RA course appears successful in teaching new skills as well as offering emotional and peer support for a variety of writing issues. Few clergy interventions, as identified in Chapter five, focus on more than one health facet. The RA course stood out as a successful worked example of participants with varying issues using a group session to collectively seek solutions and offer and receive peer support. Additionally, the RA course aligns with the current clergy intervention literature whereby many of the works comprise a time of teaching, personal reflection, and group discussion, with or without additional activities around the subject (Abernethy et al., 2016; Davis, 2011; Smith, 2016).

6.7.1.2 Previous International Literature.

As observed in the previous chapter's international intervention literature review, certain elements feature heavily. Given the author's limited resources, the following aspects could be practicably incorporated into the current study:

- A taught holistic self-care section, incorporating the author's professional knowledge, Christian beliefs, and personal experiences.
- A time of personal reflection, contemplating the taught session and any areas for change or improvement.
- Group work which promotes discussion, peer support, and peer problem solving.
- Theological grounding, including spiritual and theological components with which participants can identify.
- Trained medical practitioner input as per the author's skill set.

6.7.1.3 Learning Preferences from the Qualitative Phase.

In addition to the RA course, and observations from the international literature, the participants in the qualitative investigation in Chapter four were also asked what elements would be most appealing to them in a self-care intervention. Participants suggested the following:

Variety of Activities

Several participants discussed the need to do a variety of activities to remain engaged and digest the learning in practical terms:

B20 - *…it's got to be a mix of things, I think there's reading to do, your seminars, video.*

B27 - *I like to have a bit of everything that informs me rather than just one thing.*

Group Work

Almost all participants cited the necessity for group work, particularly the opportunity to share and discuss ideas:

B3 - *I think, peer to peer stuff would be the number one for me*

B8 - *I find value in talking to others about it, so I do like the interactivity... someone brings something and then we all discuss it.*

B10 - *I think that back and forth stuff is really good for me to learn stuff, like people being able to ask questions to draw stuff out is really good.*

Reflection, Time Out or Away

Several participants discussed the idea of reflection and creating time and space for reflection. One participant said: "For me, it's about creating the space, taking you out of where you would normally be, to somewhere that's peaceful and quiet" (B11). Others liked the idea of dedicated conferences, as this similarly

provided dedicated space to consider select topics. A potential rationale for this was the idea of permission, “I feel that if there is a conference particularly there’s a degree of permission about being there, and I think that’s very helpful for ministers” (B23).

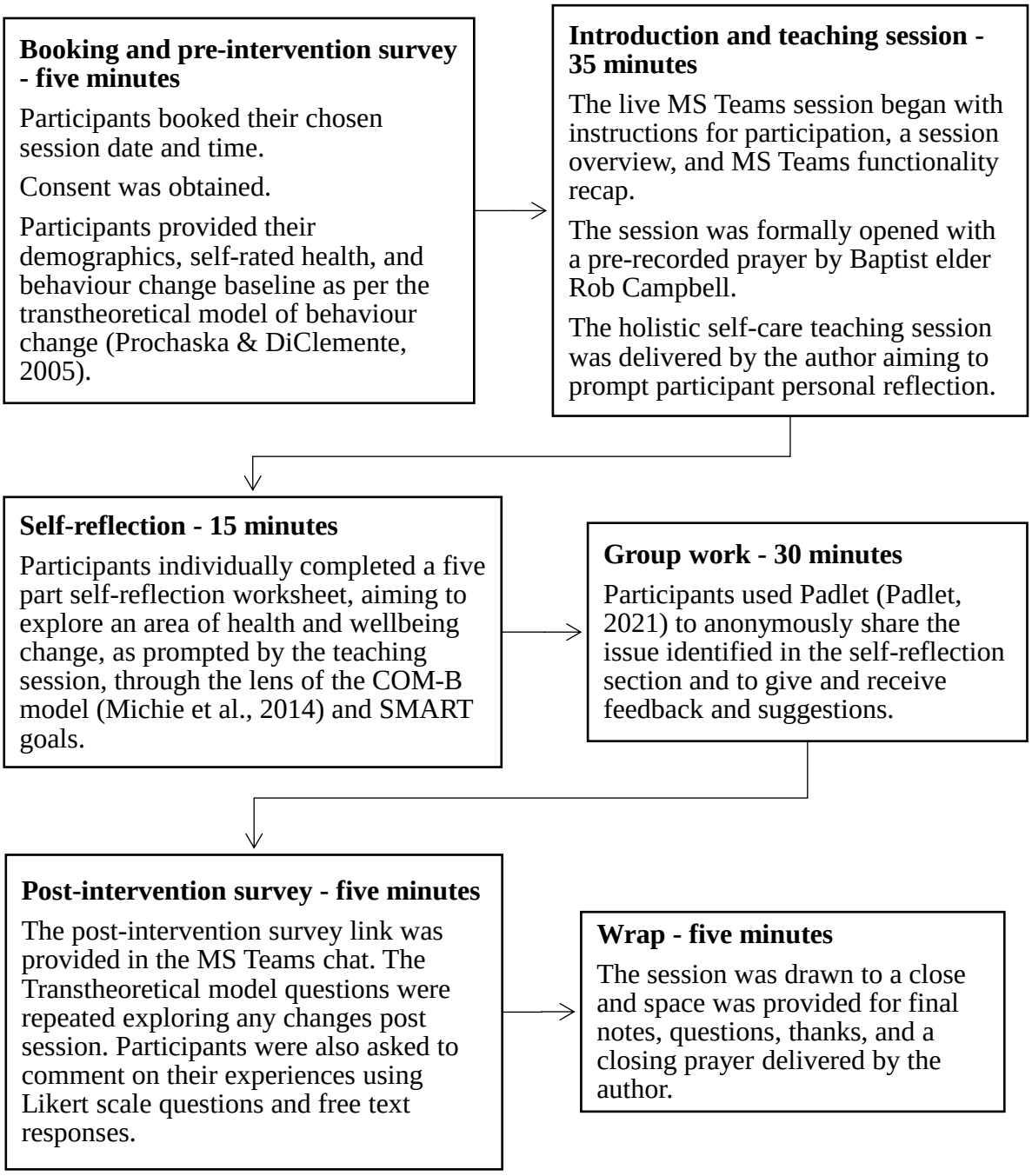
Instruction and Input

A large proportion of participants stated that they would appreciate some type of instruction or input, usually prior to individual or group work. This participant contextualised the place of instruction well when they stated: “…it’s seminar based …I mean in the context of an hour and a half, there’s 20-minutes of input, quite a major part of it is discussion, you know maybe 10-minutes of input at the end” (B18). Most importantly, participants suggested the idea of input followed by action, either personal action in their own time or group discussion and strategizing: “…that involves a practical element where you actually get the input, you get the theory, you have some discussion, so you do the reflection together” (B16).

6.7.2 Procedure

Figure 9

Intervention Flow Diagram



6.7.2.1 Justification of Online Delivery.

The intervention was delivered online using MS Teams. Although the UK was moving away from COVID-19 control measures at the time of the intervention, social distancing measures were still selectively implemented by many independent businesses and organisations. As no UK central hubs exist for the Baptist clergy population, online delivery allowed for this widespread workforce to engage from multiple locations. Internet mediated interventions have been shown to be as effective as face-to-face interventions for health behaviour change (Wantland et al., 2004) and have been used for a variety of health behaviour change strategies (Ruggiero et al., 2006).

6.7.2.2 Booking and Pre-intervention Survey – Five Minutes.

Participants were recruited using a snowball sampling method. With the help of the BU, the session flyer (Appendix Q) was emailed to each accredited minister within the network. Additionally, the flyer was posted on several prominent clergy social media platforms. The flyer contained a QR code and web link to Online Surveys where clergy could select their chosen session. Upon completion of the pre-intervention survey (Appendix M) clergy were emailed with the Teams event and joining instructions (including their unique participant number for the group activity).

At the start of the survey, participants were asked to create an individual unique numeric identifier (comprising the last three numbers and digits of the participant's post code and phone number combined) to anonymously link the pre and post survey responses. In addition to mandatory consent questions, the short pre-intervention survey collected participants' demographics, self-rated health, and

behaviour change baseline. Self-rated health was included to give an indication of participants' perceived health status in the cohort under investigation. It is understood that holistic health is a very wide topic with numerous facets, for the purpose of conciseness, and alignment with the current literature (Proeschold-Bell et al., 2011; Terry & Cunningham, 2019) and this thesis' previous investigations, this question explored the mental, physical, social, and spiritual health domains. This self-rated health question was adapted from Peterson et al.'s (2008) holistic health investigation and is a widely accepted measure in organisational psychology (e.g., Bennet & Lindström, 2018; Chaparro et al., 2019).

Self-care action and intention to change was assessed in the pre and post-intervention surveys using the transtheoretical model of behaviour change (Prochaska & DiClemente, 2005). Developed in the mid 1980s, the model has been used in thousands of occupational psychology interventions to describe and map the process of patient and participant behaviour change (Sussman et al., 2022). The model commonly comprises five stages: precontemplation, contemplation, preparation, action, and maintenance (Norcross et al., 2011, p. 144). Iterations of the model sometimes feature two further stages: relapse (where old unhealthy patterns are resumed) and termination (where the new health behaviour has become so engrained that relapse is highly unlikely) (Prochaska & DiClemente, 2005; Raihan & Cogburn, 2023; Sussman et al., 2022). These last two stages are frequently not included, as relapse is often viewed as a step (or steps) back, and not a stage in its own right (Raihan & Cogburn, 2023; Sussman et al., 2022). Additionally, termination is less likely to be achieved, and so it is excluded (Raihan & Cogburn, 2023). The current intervention followed a six-stage format which included relapse. Whilst acknowledging the differing views on this 'stage' inclusion, assessment of

whether the intervention strategies could prompt action either from no previous action or from relapse, was sought. Overall, the use of the transtheoretical model allows for visualisation of positive health behaviour intention progression at different levels, e.g., pre-contemplation to contemplation. This distinction may be useful in future research where stage matched interventions can be targeted at specific groups with distinct health behaviours.

As the current intervention was not targeting predefined self-care actions, the survey broadly asked participants:

Thinking about your self-care in general do you already, or plan to, do anything to support your physical health?

This question was repeated for mental, spiritual, and social health. Six answer options were provided:

Maintenance - *Yes, I have been doing 'X' regularly for more than six months*

Action - *Yes, I have been doing 'X' regularly, but for less than six months.*

Relapse - *I used to do 'X' regularly but have stopped in the last six months.*

Preparation - *No, but I intend to do regular 'X' in the next 30 days*

Contemplation - *No, but I have contemplated doing regular 'X' in the next six months*

Pre-contemplation - *No, and I do not intend to do regular 'X' in the next six months*

Response options were derived from popular wording in the contemporary psychology and intervention literature (Arden & Armitage, 2008; Houdmont et al., 2019; Kearney et al., 1999).

Examples were given for each question, e.g., for physical health:

You may have started jogging recently, so you may wish to choose Yes, I have been doing 'X' regularly, but for less than six months.

6.7.2.3 Introduction and Teaching Session – 35 Minutes.

The live session was opened by the author, with assurances given to participants that there were no correct answers, and participation was welcomed in all sections. The author gave an overview of the 90-minute session and reiterated basic instructions, including MS-Teams functionality. The formal section of the session was opened with a pre-recorded prayer by Baptist elder Rob Campbell of New Life Baptist Church Northallerton (Appendix N).

The teaching session (Appendix N) used a combination of theological examples, holistic self-care knowledge sharing, and personal stories to convey a message of bible based positive self-care, aiming to prompt personal reflection e.g.,

Personal journey and wellbeing knowledge share:

As my journey progressed the links between my different areas of health was becoming clearer. …But what I learned is, our minds are so complex … Just one of the brain's amazing functions is that when something breaks, either emotionally or physically, we have a function called neuroplasticity that enables us to 'grow' new neural pathways (brain connections) allowing us to overcome the most difficult of issues.

Theological example prompting personal reflection:

His (Jesus) ministry was not purely focussed on spiritual matters alone … What he (God) *does want (as he does with our spiritual health) is a degree of responsibility, reflection, action, and living example.*

This interweaving of theology, personal example, and health knowledge is inspired by the interventions featured in the systematised literature review (e.g.,

Emmons [2015] Scott [2015] Webb and Bopp [2016] and Proeschold-Bell et al. [2017]).

6.7.2.4 Self-reflection – 15 Minutes.

Participants were encouraged to turn their microphones and cameras off to complete the self-reflection sheet (Appendix O). Participants were given 15-minutes to complete the sheet, a verbal five-minute warning was given before the end of the section. Participants had the option of filling the form in digitally or printing it out and filling it in with a pen. Manual completion was encouraged, in order to give participants a short screen break. Participants were reminded that the forms would not be collected and were to be used as a personal reflective tool for their wellbeing and the following group activity.

The self-reflection worksheet comprised five sections:

Section one - supported general self-care reflection. The question asked participants to reflect on a specific area of their personal health, e.g., mental, physical, social etc., and what they might like to change or improve:

Thinking about one of the health areas, e.g., physical health, what would you like to change if you could? What do you struggle with? What might help you in this area?

Section two – asked participants to consider their desired area for change more closely using wording and prompts from the COM-B-Qv1 self-evaluation tool (Michie et al., 2014, p. 68-69). The COM-B model posits that for a behaviour to be completed the individual must have resources across capability, opportunity, and motivation (Michie et al., 2014). Although there are several models of predictors of behaviour prominent in the literature, the COM-B model is a subsection of the behaviour change wheel which considers 93 influencing factors to behaviour change

(Michie et al., 2011; 2013). Most notably, these factors consider the wider range of influences to behaviour beyond the individual (akin to the socioecological model of health) that extend to environment and legislation (Michie et al., 2011; 2013).

The COM-B model is sometimes viewed as supplanting Ajzen's (1991) theory of planned behaviour. One sitting time study indicated that the COM-B model accounted for 27% of the variance in sitting time, whereas the theory of planned behaviour accounted for 23% (Howlett et al., 2021) indicating the model is more of a parallel tool, rather than a replacement. The rationale for the COM-B selection in this investigation resides in the behaviour change wheel. Although the full behaviour change wheel itself will not be used in this intervention, the wheel is a useful consideration in future research extending from this project. The taxonomy of the wheel may help individuals, policy makers and support agencies target and improve select areas that have been previously neglected, indeed Public Health England (2019) advocate for this approach.

This question invited participants to circle answer options that best described their current feelings around the area of challenge.

- Ten answer options were provided for capability, e.g., *Have more physical strength*, or *Have more mental stamina*.
- Seven options were presented for opportunity, e.g., *Have more time to do it,* or *Have more support from others*.
- Six options were given for motivation, e.g., *Develop better plans for doing It,* or *Feel that you need to do it enough*.

An example was provided for clarity:

If you would like to start exercising, you may circle in capability, 'Have more physical stamina', 'Know more about how to do it', In opportunity, 'Have more time to do it', 'Have more support from others' and in motivation, 'Feel that you want to do it enough', and 'Develop a habit of doing it'

Section 3 – used the commonly known acronym SMART. The acronym prompts the individual to explore their intended goal considering its **S**pecificity, **M**easurability, **A**chievability, **R**ealistic nature and **T**ime frame for completion or attainment. The self-reflection worksheet provided a full worked example of a SMART goal, then gave a blank table for participants to consider their own strategy.

It is believed that despite measurable, realistic, and relevant goal setting originating circa 1940s, the acronym itself did not appear in literature until the 1980s, first cited by Doran in 1981 (Lawlor & Hornyak, 2012). The tool has been adopted globally across various health and wellbeing organisations, and, to date, remains popular (NHS, n.d.-c; Swann et al., 2023). SMART goals consider areas such as task complexity, willingness, commitment, goal importance, difficulty, and strategy (Locke & Latham, 2002). It is recognised that the wording of the SMART acronym does differ across industries. Rubin (2002, p. 26) discusses the several readily used words for each letter, 'S' for example being possibly recorded as "simple, specific with a stretch, sensible, significant". For the purposes of this intervention, the wording "Specific, Measurable, Achievable, Realistic and Time bound" were used to reflect the health and pedagogical literature (Day & Tosey, 2011; Lawlor & Hornyak, 2012; Swan et al., 2023). Some versions follow SMART with further action points and obstacle questions (Bailey, 2019; Elmhurst University, n.d.; Lawlor & Hornyak, 2012; 101 Planners, n.d.). The current intervention adopted these additions for thoroughness which led to the final two sections of the worksheet.

Section four - provided the opportunity for participants to consider any specific necessary steps to support their goals:

Are there any specific steps that would help you achieve your goal?

An example was provided:

E.g., Set some time aside to have an honest discussion with my partner about my exercise habits and what I need from them, and why it's important to me.

Section five – similarly provided space for participants to consider potential challenges to meeting their targets:

Next consider the possible barriers…

An example was provided:

E.g., Life gets in the way, I cave and don't make the effort to go out, my partner doesn't encourage me.

Combined, the sections of this self-reflection worksheet provided a foundation for the subsequent group work section.

6.7.2.5 Group Work – 30 Minutes.

Padlet Functionality instructions were provided at the start of this section. Participants were assigned a number (one - six) at the time of booking, that corresponded to a column on the Padlet. These numbers were only known to the author and individual participants. Numbers were used to provide a degree of anonymity, where participants could post a self-care issue, and give and receive feedback and suggestions anonymously. This type of personal sharing is common in clergy development programs (Baptists Together, 2021b). Participants were asked to post one, or more, self-care struggles (as identified in the self-reflection section) in their numbered column. Participants were then given time to read and give virtual

responses (tips and advice) to the posts. The group, facilitated by the author, then discussed the struggle posts and responses.

6.7.2.6 Post-intervention Survey – Five Minutes.

After drawing the group work section to a close, a link to the post-intervention survey (Appendix M) was posted in the MS Teams chat. Participants were encouraged to turn off their microphones and cameras to complete the final survey. Once completed, they were encouraged to turn their cameras back on to signify this.

The questions in the post-intervention survey aimed to collect data on the suitability and acceptability of the intervention following the published literature. The survey began by asking for the participant's individual unique numeric identifier (created in the pre-intervention survey). The same transtheoretical model questions were then repeated for the investigated health facets following the prompt:

Having now attended the session, please consider your self-care support strategies for physical health (repeated for spiritual, social and mental health) *once again.*

The final portion of the survey asked participants to consider their session experience using a combination of 12 Likert scale statements and a free text question. The single answer statements sought to assess the clarity, enjoyment, usefulness, relevance, and length etc. of the session. For example:

The session was the right length.

I found the session personally relevant.

I found the session engaging and enjoyable.

These statements were inspired and adapted by other intervention literature evaluations (Craig & Austin, 2016; Greenwell et al., 2021; MacCarthy et al., 2021;

Ruggiero et al., 2006; Webb & Bopp, 2017; Wieland et al., 2017). Five response options were provided for each statement: *Strongly disagree, Disagree, Neither agree nor disagree, Agree, and Strongly agree.*

The final question asked participants to comment on their personal experience of the session including pros and cons in a free text response.

6.7.2.7 Wrap – Five Minutes.

Once the final survey had been completed, the group reconvened with cameras on for final notes, questions, thanks, and a closing prayer (as is the social norm in the cohort) delivered by the author (Appendix N).

6.8 Reflexivity

As with the previous studies in this thesis, it is useful to explore the author's potential bias and influence on the work. The most obvious potential bias is the inclusion of the author's personal health experiences in the teaching section. Following previous clergy intervention work, this approach appeared impactful and effective in prompting behaviour change (Emmons, 2015). The use of story makes the work personal. It is acknowledged, however, that not all participants would identify with the story, struggles and challenges, and indeed some may even feel disconnected from the work. The use of personal story in this instance was a driver for the author. The author sought to share their experience and depict health struggles (and overcoming them) as a prompt for clergy, and in doing so was passionate in delivery, connected and invested in the work.

Only one participant was personally known to the author. It is acknowledged that the information they shared may have been influenced by the author-participant

dynamic, however this participant requested to join and appeared unencumbered in their contributions.

It is acknowledged that the author's personal makeup may have impacted participants' responses to the intervention. For some this may have helped information digestion, for others this may have prompted disconnection (e.g., the author's androgenous name). Some of these factors, however, may have prompted involvement and discussion with an outsider to the profession. Additionally, the author is a practicing Christian. This factor offers a connection to the participants that may transcend other differences, and aid discussion of theological and spiritual terms and practices. This did appear to be an important factor for some participants, one personally wrote to the author after the event to share:

It was such a privilege to hear your story on Wednesday. Thank you for what you are doing and the life you are bringing. I wanted to message to encourage you and say that I believe the Father God would want you to know how proud he is of you and what you are doing… (Anonymous)

Finally, it is acknowledged that sense making from the data in this study may be affected by the author's medical background, theological stance, and previous personal and professional knowledge and experience of holistic self-care. To mitigate any unintentional effect on leading the intervention and data interpretation, processes and reflections were discussed with the author's supervisor and critical friends.

6.9 Analytical Approach

Although there is no gold standard for feasibility study evaluation, the current study uses the framework set out by Gadke et al. (2021) inspired by the

works of popular intervention authors such as Tickle-Degnen (2013) and Bowen et al. (2009). The framework evaluates feasibility and acceptability using 10 criteria (Gadke et al., 2021, p. 4):

1. Recruitment capability

   Can participants who will benefit from and who will implement intervention be identified?

2. Data collection

   Are data collection procedures and outcome measures appropriate and sensitive to change?

3. Design procedures

   Is research design appropriate and sensitive to evaluating change?

4. Social validity

   Do participants perceive the intervention as appropriate, reasonable, fair, and potentially effective?

5. Practicality

   Can the intervention be implemented with available resources, time, training, and materials?

6. Integration

   To what extent is the intervention aligned with the infrastructure of the practice setting or system?

7. Adaptability

   Is there sufficient flexibility built into the intervention procedures to accommodate diverse needs?

8. Implementation

Are professionals able to implement the intervention with fidelity (as intended by the developers)?

9. Effectiveness

   Is there preliminary evidence of potential for bringing about positive change?

10. Generalizability

    To what extent do intervention procedures generalize to non-treatment settings, over time and with diverse samples?

These 10 criteria (not in the above order) will be explored in the results section.

6.10 Results

Eleven participants fully engaged in all parts of the intervention (completed the pre and post surveys and participated in the 90-minute seminar session).

6.10.1 Recruitment Capability

"Can participants who will benefit from and who will implement intervention be identified?" (Gadke et al., 2021, p. 4).

The following describes the recruitment process and participation. Overall, it is evident that the recruitment process faced some challenges and may require adjustment prior to piloting.

6.10.1.1 Procedure.

Upon ethical approval, advertising began in early June 2022. Connections within the BUGB email the study flyer to all registered BUGB UK Baptist ministers.

Two sessions were organised, one for Wednesday the 27th July morning, 10:00-12:00 and the second for Friday the 29th July afternoon, 13:00-14:30. Despite the wide reach of the BUGB, interest in the intervention was low. The day prior to the first session 11 participants had signed up across the two sessions. Six participants had booked for the Wednesday session. However, two participants dropped out 10-minutes before commencement. One gave the reason of personal wellbeing and preparing for funerals, and one did not give a reason. One further delegate did not turn up, they emailed after the event giving apologies, but were unavailable to take part in a further session. For this session three participants fully completed the session and both parts of the survey.

Five participants, plus one tentative participant had signed up for the Friday session. The one tentative participant pulled out due to holiday commitments, and one was unable to participate due to connectivity issues. This left four participants for the session. One participant did not complete the post-intervention survey, leaving data from three participants for analysis.

Due to the poor attendance of the first two sessions an ethics extension (Appendix P) was requested until the end of September. On the 17th August, four more dates were advertised for late September. The BUGB re-contacted the ministers for their participation, and the study flyer was also posted across several UK social media groups. Despite widely advertising, only six participants signed up for a final session on Wednesday the 21st September. All booked participants attended and participated in the live session. One participant, however, failed to complete the pre-intervention survey, leaving five fully completed responses, 11 in total across all three sessions.

6.10.1.2 Demographics and Population Characteristics.

The participant sociodemographic and occupational characteristics can be viewed in Table 37 and Table 38. Of these, 73% identified as male, 46% of participants were main ministers aged between 55 and 65, and 72% had 11+ years ministerial experience.

Table 37
Participant Sociodemographic Characteristics

	N (%)
Gender	
Male	8 (73)
Female	3 (27)
Age	
35-44	2 (18)
45-54	2 (18)
55-64	5 (46)
65-74	2 (18)
Marital status	
Single	0
Married	11 (100)

Note. Percentages have been rounded to the nearest whole number.

Table 38
Participant Occupational Characteristics

	N (%)
Role	
Main minister (e.g., senior pastor)	5 (46)
Co-minister (e.g., associate pastor)	1 (9)
Youth pastor / leader	1 (9)
Other:	
Community chaplain	2 (18)
Evangelist and principal	1 (9)
Regional minister	1 (9)
Years of experience	
≤5	1 (9)
6 -11	2 (18)
12-17	1 (9)
18-23	1 (9)
24-29	2 (18)
30-35	3 (27)
36-41	1 (9)

Note. Percentages have been rounded to the nearest whole number.

6.10.1.3 Self-rated Health.

Self-rated health was included to align with previous studies and explore the health perceptions of those participating. Across participants, self-rated health was somewhat split. As expected, spiritual health was the most positively rated domain, with 64% stating their health in this area was good or excellent. Mental health appeared the lowest rated domain, with 64% rating this area as very poor, poor, or fair. Physical and social health appeared the most evenly split, with 55% of

participants citing their health as good or excellent in both domains. Results can be observed in Table 39.

Table 39
Self-rated Health

Facet	Very poor *N* (%)	Poor *N* (%)	Fair *N* (%)	Good *N* (%)	Excellent *N* (%)
Spiritual health	0	1(9)	3(27)	6(55)	1(9)
Mental health	1(9)	1(9)	5(46)	3(27)	1(9)
Physical health	0	0	5(46)	5(46)	1(9)
Social health	0	2(18)	3(27)	6(55)	0

Note. Percentages have been rounded to the nearest whole number.

6.10.2 Data Collection

"Are data collection procedures and outcome measures appropriate and sensitive to change?" (Gadke et al., 2021, p. 4).

Although statistical analysis and outcome evaluation is not sought in feasibility interventions (Arain et al., 2010, p. 5) assessment of the measures used to assess change and evaluate the intervention are necessary. Namely, can sense be made from the data collected (Gadke et al., 2021). This intervention used a pre and post-intervention survey to assess change. As the surveys were anonymous, they relied on the participants' honesty at the start and end of the session in response to the session leader's verbal question confirming all participants had completed the required sections.

The post-intervention survey was built into the session time. The qualitative portion of this invited participant's free text evaluation of the session. All 11 participants provided a short comment. The average length of these comments was 39 words (Table 39). The participant generated personal identifier used to link both pre and post-intervention responses worked well. No participants reported any difficulty remembering their number using the postcode / phone number sub-section amalgamation.

The 12 Likert scale evaluation questions (Table 38) provided useful information regarding the personal acceptability, usefulness, and relevance of the session. Responses showed 100% of participants agreed, or strongly agreed, that the session was personally relevant, and 91% agreed, or strongly agreed, that the session prompted them to consider changes to their self-care practices. Additionally, 82%

agreed, or strongly agreed, that the session suited their personal learning style, and a suitable mix of activities was provided. As part of these questions, 27% stated that they neither agreed nor disagreed regarding the appropriateness of the session length. This, however, was clarified in some of the qualitative comments where some stated more time in the group work would have been advantageous, e.g., “Longer for participants to share concerns would have been good - this section went very quickly, and I felt there was more wisdom to be tapped into” (B8). Taken together, these evaluative measures provide useful information for adapting the intervention with regards to time allocation in future iterations.

Finally, the transtheoretical model questions indicated sensitivity to change. Across the four domains of health explored, output data showed nine instances of movement towards positive behaviour change across the precontemplation, contemplation and preparation stages (Tables 40 and 41). Six participants indicated intentions towards positive behaviour change. This intention was observed across all four domains of health. Three participants indicated intention to change in two different domains.

6.10.3 Design Procedures

“Is research design appropriate and sensitive to evaluating change?” (Gadke et al., 2021, p. 4).

Although this type of intervention does not, to date, feature in the literature in this country or cohort, the intervention components have been informed by a comprehensive systematised review of all previous published clergy interventions. Additionally, as explored in detail in the design inspiration section, the procedure and technological platforms adopted in this intervention followed tried and tested

pedagogically sound procedures, e.g., the RA protocols. Alongside the design, underpinning literature, and protocols followed, the intervention provides measurable outcome data demonstrating the personal acceptability, and personal efficacy of this study. Aside from process limitations around recruitment, the design of the intervention appeared, in this iteration, to achieve what it set out to do as per the research question and logic model (Figure 8). Measurable quantitative and qualitative data has been produced that indicates the personal acceptability (see social validity) and effectiveness (see effectiveness) of the intervention.

6.10.4 Social Validity

"Do participants perceive the intervention as appropriate, reasonable, fair, and potentially effective? (Gadke et al., 2021, p. 4).

The social validity and acceptability of the intervention was assessed using the participants' responses to the 12 Likert scale evaluation questions (Table 40). As well as exploring the personal usefulness of the intervention, these questions sought to examine if the session was personally appealing in addition to being a valid and appropriate method to address self-care behaviours in the Christian context. Overall, 91% agreed, or strongly agreed, that the session prompted them to consider changes to their self-care practices. In this group, 82% agreed, or strongly agreed, to the statements regarding finding the session engaging and enjoyable, that the session suited their personal learning style, and that they found the main individual sections of the session useful. Asked if they would attend this type of session again, 64% of the participants stated they agreed, or strongly agreed. Four participants stated they neither agreed nor disagreed with this statement, however, an examination of their qualitative responses (Table 41) highlighted possible rationales for this. One

participant (B9) stated they did not like the online format. One participant (B5) appeared to be hoping for more in-depth discussion surrounding spiritual health, stating: “I found it interesting that no participants really mentioned spiritual health... Do we lack the language / confidence / ability / experience to talk about spiritual health?” The third participant (B7) stated they wanted a shorter introductory section and more prompts for the group discussion. Finally, the last participant (B11) attended the first session with only three participants, and as such, stated too few people attended the session.

In response to the statement if the session discussed theology in an appropriate way, 73% agreed, or strongly agreed. Of the three participants who neither agreed nor disagreed, two did not elaborate on the theological content in their free text response. The final participant (B1) also did not elaborate on the theological content but did state they found the session “affirming” and “helpful in helping others”. As personal understanding of theology can differ greatly in the same denomination (e.g., the topic of sexual identity [Haward, 2016]) it is likely, given no further comments were made, this was a matter of personal preference.

Table 40
Post-intervention Participant Evaluation

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
			N (%)		
I found the session engaging and enjoyable	0	1(9)	1(9)	4(36)	5(46)
It was clear what was expected of me during the session	0	0	2(18)	5(46)	4(36)
The session prompted me to consider changes to my self-care practices	0	0	1(9)	6(55)	4(36)
I feel the session had a good mix of activities	0	0	2(18)	7(64)	2(18)
I feel the session discussed theology in an appropriate way	0	0	3(27)	4(36)	4(36)
I found the session personally relevant	0	0	0	7(64)	4(36)
The session was the right length	0	0	3(27)	6(55)	2(18)
The session suited my personal learning style	0	1(9)	1(9)	8(73)	1(9)
I found the teaching session with Jamie useful	0	0	2(18)	3(27)	6(55)
I found the self-reflection session useful	0	0	2(18)	6(55)	3(27)
I found the group work useful	0	1(9)	1(9)	8(73)	1(9)
I would attend this type of session again	0	0	4(36)	4(36)	3(27)

Note. Percentages have been rounded to the nearest whole number.

Table 41
Participant Qualitative Evaluation

Participant number	Comment	Number of words
B1	Curiosity satisfied. Helpful in helping others who approach me as a sort of informal mentor, affirming in that I think I've fought a lot of these battles and come through, if that doesn't sound conceited.	34
B2	I found the session helpful, and comments made useful. I thought it would have been better with more people on screen but that cannot be helped. The Padlet would have worked better with more people although a smaller group did allow intimacy, so sharing was easy.	46
B3	I really felt God speak through listening to others and what they were going through. I also found the session incredibly affirming, and I began to recognise the aspects of self-care I do put in place.	37
B4	It was a good intro and provided good first steps on the subject.	14
B5	It was good to think about health in a holistic way. I found it interesting that no participants really mentioned spiritual health - either in the area that they wanted to discuss, or in the suggestions they were giving to others. Do we lack the language/confidence/ability/experience to talk about spiritual health? It was great that the group work had an option to be anonymous. For an improvement, it would have been good before the session to say that the group work would be anonymous, as that would reassure people. Thank you! I hope it has been helpful for you.	99

B6	It would have been better to see Jamie rather than just hear her voice[a]. A measure of allowing everyone to share perhaps more concisely their thoughts could have improved the session. Otherwise very good and worthwhile.	36
B7	On the whole this session was helpful - however we may wish to consider less of a detailed introduction and a more productive stimuli for group interaction. I acknowledge this is difficult on Zoom.	34
B8	Participants had good control over what they shared (or chose not to) - respectful processes used. Used to participants introducing themselves in sessions and thought it odd at first, but this maintained a sense of anonymity (see above). Longer for participants to share concerns would have been good - this section went very quickly, and I felt there was more wisdom to be tapped into. A follow up session would be interesting.	72
B9	Session leader was excellent, she led us very well and she was clear in her intentions in how she wanted to help us. Didn't like that it was online but that's personal preference.	33
B10	Thought it was really helpful and something that definitely needs highlighting.	11
B11	Too few people attending. Where are all the younger people no a-fence to anyone.	14

Note. [a] - the author's camera was briefly turned off in one session due to low band-width leading to a synchronization lag. Participants were informed of the rationale for this.

6.10.5 Practicality, Adaptability, and Implementation

"Can the intervention be implemented with available resources, time, training, and materials?... Is there sufficient flexibility built into the intervention procedures to accommodate diverse needs?... Are professionals able to implement the intervention with fidelity (as intended by the developers)?" (Gadke et al., 2021, p. 4).

As these criteria all sit under the umbrella of functional suitability (Gadke et al., 2021) they will be assessed together. First considering practicality, namely, outside of the current context if another researcher could deliver the intervention in its current format. The most prominent possible issue is the teaching section, which included the author's personal story. This, however, could be pre-recorded and shown during a session in the absence of the author. Anecdotally, the author has had personal experience during the COVID-19 lockdown period of delivering pre-recorded talks in the church setting for the Northern Baptist Association (New Life Baptist Church Northallerton, n.d.). These talks were used in individual small (cell / house) groups, and as part of the main Sunday service. The format of pre-recorded reflective video, followed by a guided group discussion or activity, is a well-used format within evangelical churches, made popular by authors such as Rob Bell and their Nooma series (Zondervan, 2024).

As the aim of the intervention is to prompt self-reflection and positive behaviour change, outside of the initial teaching section no specialist medical knowledge or training is required to deliver the session. As such, a non-medical research team would be able to deliver the intervention with general group leadership and discussion facilitation skills.

The intervention was carried out online, which allowed clergy, irrespective of geographical location, to attend. This online format, however, required additional screen time in a historical period of excess screen and technology use. The obvious area for potential adaptation, therefore, is transferring the intervention to a face-to-face format. This adaptation could be achieved when allowing for the pre-recorded video. The original format of the Researcher Academy Getting to Grips with Academic Writing course (The University of Nottingham, n.d.-b) which the current intervention took inspiration from, was face-to-face. The Padlet section was originally conducted using flipchart paper and sticky notes. As such, adapting the session for an alternative environment could be deemed feasible.

The implementation of the intervention did not raise any significant issues. Despite the lower than anticipated group numbers, all clergy participated in the required activities of the intervention. No practical issues were raised in the overall delivery; 82% agreeing, or strongly agreeing that it was clear what was expected of them during the session. Implementation as discussed by Gadke et al. (2021, p. 9) explores other factors, including participant understanding, enjoyment and engagement. As shown in the social validity section, this intervention was, overall, well received by participants, with 82% finding the session engaging and enjoyable.

6.10.6 Integration

"To what extent is the intervention aligned with the infrastructure of the practice setting or system?" (Gadke et al., 2021, p. 4).

Gadke et al. (2021, p. 8) suggest exploring "…the extent to which a proposed intervention is aligned with the unique features of the practice setting". The overarching aim of the intervention aligns with the theology of this denomination, as

discussed in Chapter one, there is a clear biblical basis for holistic self-care. This was also explored in Study two where those interviewed unanimously cited a biblical imperative, Christian and ministerial, to self-care. Theologically, therefore, this intervention integrates well.

Potential integration issues arise when considering the culture of individual churches and clergy's perceived permissions to self-care as a barrier to change. As highlighted in Study one of this thesis, perceived support may be complex in this denomination. Amongst those surveyed, 20% rarely or never felt support to self-care from their leadership, and 26% rarely felt support from their congregation. Therefore, it would be advantageous to measure any sustainable change brought about by this intervention longitudinally.

6.10.7 Effectiveness

"Is there preliminary evidence of potential for bringing about positive change?" (Gadke et al., 2021, p. 4).

Although not a goal of feasibility interventions, it is advantageous to examine potential change brought about by the intervention (Gadke et al., 2021, p. 9) and if the intervention in preliminary testing is efficacious. Effect in this intervention was measured in migration through the stages of the transtheoretical model of behaviour change. As discussed in the design procedures section, the model was sensitive to change in this group. Table 42 shows where participants sat for each of the four domains under investigation pre-intervention. Table 43 shows post-intervention changes. Six participants indicated change in stage across the four domains (mental, physical, spiritual and social):

- **Participant B2** - Physical domain, moved one stage (maintenance to contemplation of a new activity). Mental domain, moved one stage (contemplation to preparation)
- **Participant B6 -** Social domain, moved one stage (contemplation to preparation)
- **Participant B7** - Physical domain, moved one stage (contemplation to preparation). Social domain, moved one stage (precontemplation to contemplation).
- **Participant B8** - Physical domain, moved one stage (contemplation to preparation).
- **Participant B9** - Spiritual domain, moved two stages (precontemplation to preparation). Social domain, moved two stages (precontemplation to preparation).
- **Participant B11** - Mental domain, moved two stages (precontemplation to preparation).

These data are suggestive of efficacy of the intervention in this group to promote positive holistic self-care behaviour change. As such, the changes observed in this group provide an argument for efficacy assessment in larger scale piloting and full roll out with longitudinal appraisal.

Table 42
Pre-intervention Stage of Change as Per the Transtheoretical Model

Facet	Precontemplation	Contemplation	Preparation	Action	Maintenance	Relapse
			N (%)			
Spiritual health	1(9)	1(9)	1(9)	1(9)	7(64)	0
Mental health	3(27)	1(9)	1(9)	2(18)	4(36)	0
Physical health	1(9)	2(18)	0	2(18)	5(46)	1(9)
Social health	2(18)	3(27)	1(9)	0	4(36)	1(9)

Note. Percentages have been rounded to the nearest whole number.

Table 43
Post-intervention Positive Stage of Change Observance

Facet	Change of stage observed	No change observed
	N (%) number of stages moved	*N* (%)
Spiritual health	1(9)2	10(91)
Mental health	1(9)2, 1(9)1	9(82)
Physical health	3(27)1	8(73)
Social health	2(18)1, 1(9)2	8(73)

Note. Percentages have been rounded to the nearest whole number. All changes were observed across the precontemplation, contemplation and preparation stages.

6.10.8 Generalisability

"To what extent do intervention procedures generalize to non-treatment settings, over time and with diverse samples?" (Gadke et al., 2021, p. 4).

Generalisability refers to the extent to which the intervention may be successfully implemented across different populations, in different settings, and across time, outside of the strict experimental setting (Gadke et al., 2021). In the context of this intervention, this means delivery by different and non-medical practitioners, in different settings (online, in-person, as part of an existing event, or as a stand-alone session) and effects measured over time. As discussed in the previous sections, this intervention, by design, is practical and adaptable, and methods are available to maintain the essence of the original author's intent and message. Although generalisability was not measured in this feasibility intervention, at pilot stage and beyond this may be measured by utilising this study's data using a generalisation map to explore differences across the domains of time, setting, behaviours, and subjects (Allen et al., 1991).

6.11 Discussion

This study aimed to assess the feasibility and acceptability of an online tailored holistic self-care intervention for UK Baptist clergy using Gadke et al.'s (2021) 10 stage evaluation. Feasibility and / or acceptability was observed across all criteria, however, some challenges were highlighted.

6.11.1 Observations and Interpretation of Findings

6.11.1.1 Recruitment.

The main issue identified was in participant recruitment and the subsequent small sample size which affected social validity when considering group size and ease of discussion. Although it is not known why this intervention attracted small numbers, as discussed, permissions and support from both leadership and the congregation may impact clergy's perceived availability to attend self-care activities. Notably, Staley et al. (2013) in their trans-denominational investigation of clergy interpersonal isolation, also found difficulties with recruitment to the extent that elements of their original design were excluded. Although they did not provide any reason for the low participation rate in their study, their results did suggest a significant barrier to social interactions was time. This is indicative that time may also be a factor in participating in additional or optional self-care activities. In any future iterations therefore, it may be useful to assess:

- If the intervention were part of an existing event such as a retreat, conference, or quiet day, clergy may be more inclined to attend.
- Holding the intervention at different times of the year may attract more participants.
- Although morning and afternoon sessions were offered, varying times to offer early morning or evening sessions may be helpful and align with some participants' personal quiet or study times.
- Although every effort was taken to widely advertise the event using the BUGB and social media, staggering and repeating the advert well in advance of the intervention may capture more views. Earlier

advertising may encourage clergy to protect time in advance, rather than carve it out at a later date.

- Some clergy may prefer in-person participation, and as discussed, this intervention could easily be adapted to an in-person version. This may, however, limit participation through geographical location, or additionally, this method may incur travel costs.
- One participant stated that they liked the anonymous option for group sharing, stating: “For an improvement, it would have been good before the session, to say that the group work would be anonymous, as that would reassure people” (B5). Exploring if, during the advertising process, ‘anonymous sharing’ could be emphasised for increased participation, may be advantageous.

Self-paced engagement may attract more participants and would be feasible with some of the intervention’s elements, however, the rich discussion and peer-support that some clergy sought may be lost when using this formula. Additionally, it is known that social interaction is linked to positive health (Kemp et al., 2017, p. 406) for example Harmon et al. (2021) suggest clergy dietary intervention success based upon ‘camaraderie’ between participants.

6.11.1.2 Data Collection.

The data collection methods and procedures generally worked well. One participant did not complete the post-intervention survey, and as such their responses were excluded from analysis. Better prompting and vigilance from the session leader is required in checking and matching pre and post responses before starting and dismissing the sessions.

Allocating more time for participants to complete the post-intervention survey may aid in capturing more detailed responses in the qualitative portion of the evaluation. Altering the position of the free text response to earlier in the survey may also be beneficial. Galesic and Bosnjak (2009) suggest that items positioned later in online surveys may elicit shorter responses from participants.

6.11.1.3 Social Validity.

Although no participants strongly negatively responded to any portion of the intervention, some responded ‘Disagree’ or ‘Neither agree nor disagree’ to some post-intervention questions. As there was little elaboration in the free text section regarding these responses, it may be advantageous to provide a prompt to elaborate further when disagreeing. This, in addition to allocating more time to the post-intervention survey, may help participants share more detailed feedback on their experiences for future improvement.

6.11.1.4 Integration.

Notably, there appears a dichotomy between the necessity for improved self-care practices (as shown in this thesis’ studies and the wider international works) and clergy’s apparent willingness to participate in such activities. The exact rationale for participation (or lack thereof) are unknown. Clergy participants in this thesis’ previous works cited low levels of perceived support and permission from their congregation and leadership teams to self-care, ergo engagement or lack of engagement rationales may warrant further investigation.

The intervention aligns theologically and medically. However, individual church culture and wider institutional culture may require further assessment in terms of knowledge and support strategies to promote positive, sustainable holistic

self-care. Indeed, Harmon et al. (2021) found that programs designed to support the physical health of clergy cannot ignore the relationships of their spouses or the congregation. Therefore, although this intervention is feasible on a short term individual integrative level, more research may be advantageous to explore any long-term sustainability issues, considering other influential clergy relationships as per the socioecological model.

6.11.1.5 Overall Feasibility and Acceptability.

Despite the issues raised with recruitment and the minor concerns with some elements of the post-intervention survey, the sessions' positive outcomes significantly outweighed these challenges.

- Data collection tools and measures were effective and showed sensitivity to change in self-care behavioural intention.
- Participants enjoyed the session, found it personally relevant, agreed that it promoted them to consider their self-care, and would attend the session again.
- The session is practical, adaptable, and implementable by both participants and future researchers.
- The session aligns with Christian theology and integrates with personal clergy holistic health understanding.

6.11.2 Directions for Future Research

As this intervention has demonstrated feasibility and acceptability in this cohort, the next direction for future research is piloting. Any future piloting would

require attention to recruitment and consideration of the other minor concerns with the post-intervention survey.

Although this intervention was not designed as a series, due to its clear sections, additional speakers could easily be pre-recorded and delivered in section one using a similar format. Social support and group cohesion may be useful elements to explore if further sessions were offered as part of a series. This may be appropriate, as one participant stated their interest in a follow up session.

6.11.3 COVID-19 Impact

The residual effects of the COVID-19 restrictions may have affected this research, particularly when considering the required technology use and subsequent recruitment issues. As highlighted in the qualitative portion of this thesis, some clergy identified a barrier to holistic self-care as “Rapid technology skill building and overuse”. As such, this may have prevented some from attending this online intervention. That said, delivering the intervention online was perceived as the most wide reaching, cost effective, and inclusive method available.

As with this thesis’ previous studies, it was noted that public mental wellbeing was negatively impacted by the events of 2020/2021 (Mind, 2021; Vizard & Joloza, 2021) this may have prevented some from participating. Conversely, this may have attracted some clergy who were eager to make changes, given the pressures experienced during this period. Both of these possibilities may have potentially skewed results.

6.11.4 Strengths and Limitations

The results of this feasibility intervention were obtained from a small sample, and any conclusions or observations in positive health shifts are limited to this

cohort. As this is a feasibility study, however, this sample, despite its size did suggest sufficient acceptability and feasibility to warrant further testing in a pilot study.

The strengths of this intervention outweigh the sample size and other limitations. This is a pioneering holistic self-care intervention, the first of its kind, to date, administered amongst UK Baptist clergy. This intervention shows potential to be used in future large-scale interventions both online and in person. Furthermore, no necessary major revisions were identified. This intervention showed feasibility and / or acceptability in all 10 evaluation criteria providing a robust foundation for future researchers.

6.12 Chapter Conclusion

This chapter presents the procedure, results and 10 stage evaluation of a tailored holistic self-care feasibility and acceptability intervention. This study sought to explore the feasibility and acceptability of a six-step tailored Baptist self-care intervention based on this thesis' previous investigations and the wider international intervention research. It was identified that this style of intervention is acceptable to the cohort based on the evaluation criteria (Gadke et al., 2021) stage of change results, and participant evaluation. Adjustment may be needed to the publicising and advertising process, prior to piloting, to increase participation. Minor adjustments may be made in the post-intervention survey, namely the length of time for completion and prompts to ensure full completion. Although not statistically analysed, the initial results indicate that this type of intervention may positively impact the self-care practice intention of participants based on stage change in the transtheoretical model of behaviour change, and individual evaluation.

The intervention was delivered to 11 Baptist clergy. In the post-intervention evaluation survey, 100% of participants agreed or strongly agreed that the session was personally relevant, and 91% agreed or strongly agreed that the session prompted them to consider changes to their self-care practices. Additionally, 82% agreed or strongly agreed that the session suited their personal learning style, and a suitable mix of activities was provided. Participants provided mainly positive qualitative feedback from simply stating the session was a good introduction to the topic (B4) to more spiritually attuned comments regarding hearing God speak through listening to other attendees (B3).

The evaluation, initial results, and participant qualitative post-intervention comments, present an argument for the place and effective application of this type of Baptist clergy intervention. This intervention provides a foundation and justification for future piloting and formal assessment across the UK Baptist clergy population.

Chapter 7: General Discussion and Conclusions

7.1 Introduction

This chapter discusses the four interrelated works conducted in this thesis, their key findings, and practical implications for clergy in ministry. This thesis aimed to explore the holistic health, wellbeing, and self-care behaviours of UK Baptist clergy across the following:

1) Study one (Chapter three) – Health and wellbeing of Baptist church clergy: A descriptive study. This addressed the following questions:
    a. What is the holistic (spiritual, mental, physical, social, financial, and occupational) health and wellbeing profile of UK Baptist clergy?
    b. How does the sample's health and wellbeing profile compare to the extant trans-denominational Christian clergy literature and general UK adult populations?
2) Study two (Chapter four) - Baptist church clergy self-care: A qualitative investigation of perceived barriers and facilitators. This addressed the following question:
    a. What are the perceived barriers and facilitators to the holistic (physical, mental, spiritual, and social) self-care practices of UK Baptist clergy?
3) Study three (Chapter five) - An exploration of the existing literature pertaining to health and wellbeing interventions in Christian clergy: A systematised review. This review aimed to:

a. Explore the existing literature pertaining to health and wellbeing interventions in Christian clergy. Examining and extracting key characteristics, approaches, and methodologies to possibly include or exclude to promote maximal fit and efficacy in a UK Baptist cohort.

4) Study four (Chapter six) - The acceptability and feasibility of an intervention to support self-care in Baptist church clergy. This addressed the following research question:
    a. What is the acceptability and feasibility of a tailored intervention to support self-care in Baptist church clergy?

This summation chapter provides an overview of key findings from the individual studies, and further presents evidenced based recommendations for holistic self-care in ministry. The unique contribution of this thesis will be discussed alongside the overall strengths and limitations of the thesis, and the impact of COVID-19 on the research.

7.2 Key Findings

7.2.1 Profile of Baptist Clergy Holistic Health

7.2.1.1 Literature Review.

Study one was preceded by a mapping literature review which revealed minimal clergy health and wellbeing publications and research trans-denominationally in the UK. There are no Baptist holistic health or self-care investigations available, to date, in the UK. Of the available works, data indicated that clergy in these groups experience significant occupational pressures, stress

symptoms, low levels of psychological wellbeing, person role miss-fit, and dissatisfaction (Francis et al., 2008; 2017b; Francis & Rodger, 1994; Graveling, 2018a; 2018b; Rolph et al., 2014; Wyatt et al., 2017; 2019). Yet, some clergy do find significant meaning and satisfaction in their roles (Kay, 2000a; Kinman et al., 2011).

Due to the limited availability of UK works, the international literature was reviewed. These works paint a similar picture where clergy trans-denominationally appear to be experiencing health deficits against comparative adult populations (e.g., stress symptoms [CREDO Institute, 2006; Doehring, 2013; Hill et al., 2003; Holaday et al., 2001; Rowatt, 2001; Weaver et al., 2002]). This review, therefore, presented a robust rationale for the work undertaken in Study one which sought to present the first, to date, UK profile of Baptist clergy holistic health.

7.2.1.2 Baptist Holistic Health Profile.

Study one profiled the health of UK Baptist clergy and compared findings to the extant literature and UK adult populations. A sample of 55 Baptist clergy were examined using an online questionnaire. This assessed holistic health across the spiritual, mental, physical, social, financial, and occupational domains. Findings as summarised in Table 23 show holistic health concerns in all assessed domains:

Mental Health – The cohort's average mental wellbeing score fell below the national average and a significant proportion of participants reported experiencing low mental wellbeing. Yet, 38 (69%) stated they did not have any access to psychological support in relation to their role.

Spiritual Health – Clergy reported an average dissonance between their lived experience and their ideal state of spiritual health that was significantly greater than other high-pressure roles.

Physical Health – Clergy reported issues with their health that were higher than national averages, including BMI, hypertension, and sleep dysregulation. Additionally, the majority of participants did not engage in the recommended weekly moderate intensity physical activity or strengthening activity guidelines. Most notably, over half of this cohort self-rated their health as fair or poor.

Social Health – Data from this cohort suggest their social health is substantially lower than UK averages where only 17 (31%) clergy stated they met socially with friends >once per week.

Financial Health – Clergy in this study reported higher rates of difficulty making ends meet, and higher rates of additional supplementary employment than the UK population.

Occupational Health – Reported working and on call hours were at a level that was both higher than UK averages and potentially harmful to health. A significant proportion of this cohort provided responses that were indicative of exhaustion, disengagement, and burnout.

Support to Self-care – Over half of this cohort stated they did not feel supported to practice self-care activities by their church leadership or their congregations.

These findings, despite the study limitations, show similarities to the existing literature, indicating that these UK Baptist clergy experience lower levels of health and wellbeing, in some areas, than that of comparative adult populations. These data are suggestive of the necessity for improved supportive primary, secondary, and tertiary occupational health measures in this denomination. These findings provide a robust foundation for future clergy works, including the further investigations of this thesis.

7.2.2 Clergy Barriers and Facilitators to Self-care

Study one established that some UK Baptist clergy experience similar health disparities to their US, and other denominational counterparts, warranting further exploration. This second stage investigation employed qualitative techniques to examine the barriers and facilitators to positive self-care practices in a cohort of 20 clergy using semi-structured interviews. The author approached the data collection and analysis from a critical realist ontological stance, with the author assuming the existence of a true meaning of health, healthfulness, and healthy behaviours. It is understood however, that this truth is impacted by the individual's perception, experiences, personal understanding, and author's interpretation.

Interview questions were informed by the theory of planned behaviour (Ajzen, 1991, 2012). The investigation sought to explore distinct proponents of individual self-care behaviours across the spiritual, mental, physical, and social health domains. Although these facets were initially targeted, clergy discussed their health in a multifaceted and overlapping way. As such, two reflexive thematic analyses were conducted, and themes were generated following the socioecological model, as used by Lim et al. (2020) across five categories:

1. Intrapersonal
2. Interpersonal
3. Institutional / organisational
4. Christian community network
5. Societal / policy

Some issues highlighted linked directly to issues of the period (e.g., the COVID-19 lockdown) however, several issues were raised that require further investigation or intervention (Figures three - seven).

The facilitators to self-care across the socioecological model were identified as:

1. Intrapersonal – Participants cited the notable interrelationship between the health facets and the knowledge of strategies and activities that support their self-care e.g., retreats and exercise
2. Interpersonal – Friends (both in and outside church) and family supporting self-care activities and, in some cases, contributing through prayer.
3. Institutional / organisational – Formal organisational supports were identified such as a mentor, spiritual director or counsellor. Additionally, the Christian institutional notion that being healthy is a requirement prompted self-care.
4. Christian community network – Support featured heavily either in a local context for example, friends or the congregation, or in a more abstract way through the wider Christian network e.g., the Northumbria community.
5. Societal / policy – Following tradition e.g., the Jewish Shalom principle or having formal check-ins and appraisal supported self-care in this group.

The barriers to self-care were identified as:

1. Intrapersonal – Self-pressure and lack of suitable breaks.

2. Interpersonal – Linked to a lack of friends in church, social health complications arose as many participant's friends were located in other areas of the country, limiting contact.
3. Institutional / organisational – The accepted institutional norm that one full day off per week was sufficient created a barrier. As such, participants prominently discussed the potential for the job to become all encompassing. Additionally, personal spiritual health was impacted by the necessary spiritual practices of the role. Participants cited a blurring of the boundaries between personal spiritual health practices and the role requirements. Participants also voiced a significant lack of self-care training during theological college which potentially hindered their self-care once in post.
4. Christian community network – Role pressures, congregational stressors, and the perceived inability to have friends in church created a barrier to self-care.
5. Societal / policy – A distinct lack of health and wellbeing policy and guidance was identified.

Across the socioecological model, the most prominent barrier to self-care appears to be support (perceived and actual). Legal difficulties arise in obligated support strategies as clergy are not employees, but rather office holders. However, Christian moral duty remains from all agents and agencies to support clergy in a multifaceted and holistic way. Notably, however, the identified facilitators to self-care heavily featured some form of positive support, either formally in mentorship or informally from family prayer.

When comparing this study's results to the prominent international literature, significant similarities arise, namely job demands-resources imbalance, challenging intrapersonal relationships, and lack of understanding from congregants (Hill et al., 2003; McMinn et al., 2005; Proeschold-Bell et al., 2011; Lindholm et al., 2016; Wells, 2013).

This investigation, in conjunction with Study one, presents a clear rationale for further investigations, and support strategies to promote improved clergy holistic health. Additionally, these investigations provided a rationale and foundation for this thesis' final intervention study.

7.2.3 An Exploration of the Existing Literature Pertaining to Health and Wellbeing Interventions in Christian Clergy: A Systematised Review.

On 6th April 2021 a systematised review was conducted to identify the key characteristics including approaches, methods, and tools of existing clergy health and wellbeing interventions in the published literature. The aim of this search was to explore what has taken place previously and what is deemed acceptable and effective in view of informing a tailored feasibility study for UK Baptist clergy.

The review identified 18 interventions (11 journals and seven theses) that aimed to promote positive health behaviour change in clergy. All the included interventions documented some positive behaviour change in the main target health facet (and in some case additional adjacent health facets). No clear format or gold standard was identified; however, this review did identify some prominent characteristics which may be useful to incorporate and explore with a UK Baptist audience. These interventions used a combination of approaches, prominent features included group work, spirituality practices / theological grounding, taught

components, personal reflection, and holism. Although the reviewed intervention's components prompted behaviour change in the cohorts investigated, as with some of the other theses included in this review, restrictions such as time and resources, limit the inclusion of select elements. This review clearly identified components that may be explored in a UK Baptist audience including:

- A taught section (all interventions featured some form of formal teaching) including the use of personal story (Emmons, 2015).
- Holistic focus (Cutts et al., 2011; Leach, 2018; Proeschold-Bell et al., 2017; Smith, 2015).
- Group work, 13 of the interventions featured group work.
- Spiritual and theological components, 16 interventions used Christian themes and activities.
- Personal reflection, all interventions incorporated self-reflection.
- Input from a registered healthcare professional (Cutts et al., 2011; Kanipe, 2016; Leach, 2018; Proeschold-Bell et al., 2017).

The findings of this review provided a valuable foundational framework in the development of a tailored self-care promotion intervention for UK Baptist clergy.

7.2.4 Acceptability and Feasibility of a Tailored Intervention to Promote Self-care

This final investigation was informed by the previous two studies plus a systematised literature review of all available clergy health interventions. The 90-minute identical online intervention was delivered to three groups involving 11 participants. Acceptability and feasibility were assessed by pre and post-intervention surveys and Gadke et al.'s (2021) 10 assessment criteria.

The systematised literature review (Chapter five) revealed the benefits of a taught section, holistic approach, group work, theological grounding, and personal reflection. This approach was further underpinned by some of the qualitative responses captured in Study two (Chapter four). Incorporating these features, the style of the intervention was inspired by the RA Getting to Grips with Academic Writing course (The University of Nottingham, n.d.-b). The session comprised six parts:

1. Pre-intervention survey
2. Introduction and teaching session
3. Self-reflection
4. Group work
5. Post-intervention survey
6. Summary, prayer, and wrap

The pre and post-intervention survey sought to capture participant's reflections and impressions of the session in addition to the potential efficacy of the intervention for promoting positive self-care behaviour change. This efficacy was observed through movement of stage using the transtheoretical model of behaviour change (Prochaska & DiClemente, 2005). Acceptability and feasibility of the intervention was assessed and met in all of Gadke et al.'s (2021) 10 assessment criteria, however, minor procedural challenges were observed:

- **Recruitment** – more strategic recruitment strategies.
- **Data collection** – prompts and extra vigilance to ensure participants completed both pre and post-intervention surveys.

- **Social validity** – prompts to elaborate where participants disagreed with a statement.
- **Integration** – although not a target outcome of this intervention, the health and wellbeing culture of churches may require further investigation to support sustainable changes.

As discussed in Chapter six, despite the minor challenges observed, the positive outcomes significantly outweighed these minor issues:

- The tools and measures selected were understood, easily implemented, and showed sensitivity to change in self-care behavioural intention.
- 55% stated intention to change (one or more stages) across the four domains. Change was observed across the precontemplation, contemplation, and preparation stages.
- 100% of participants agreed or strongly agreed that the session was personally relevant, 91% agreed or strongly agreed that the session prompted them to consider changes to their self-care practices. 82% agreed or strongly agreed that they found the session engaging and enjoyable
- 64% agreed or strongly agreed that they would attend this type of session again. Of those who neither agreed nor disagreed, qualitative responses suggested a mixture of personal preference in format and content, plus too few attendees.
- Examination of each element of the session showed practical, adaptable methodologies that may be implemented in a future pilot.

Overall, this intervention showed feasibility and acceptability. With some minor edits, this intervention may be suitable for piloting and subsequent widespread roll out.

7.4 Practical Implications and Professional Recommendations

The studies described in this thesis highlight that clergy require complex support to maintain their holistic health and practice positive self-care behaviours. The goal of these exploratory works was to detail the level and type of need experienced by UK Baptist Clergy to underpin future research, ground level dialogue, policy and practice change. As Pluye and Hong (2014, p. 30) state: “In public health, stories have the power to change policies, and statistics traditionally provide a strong rationale to make changes”.

As previously noted, the sociological model of health is useful in subdividing areas of challenge and need. As such, the following considerations, stemming from this thesis’ results, may be useful for future researchers, individual clergy, churches, the BUGB and other supportive agencies.

1. Intrapersonal –
    a. Efforts need to be made to support individual clergy in their personal holistic health goals. Events, signposting, information, and speakers (both in-person and pre-recorded) could be used to support clergy on pertinent holistic self-care topics such as nutrition and managing your blood pressure, managing stress while supporting others, how to have friends and be a friend while being a minister, and taking a break before you break etc.

   b. Retreats, conferences, and quiet times appear important, ergo, more signposting, support, funding, and perceived permissions should be available. Links could be better established with known support agents e.g., the Northumbria Community.

2. Interpersonal –
   a. As some clergy prefer social networking outside of church and with other ministers that do similar roles, creating a bank of social opportunities, events, clubs, and hobbies may help promote improved socialising.
   b. Linking local clergy together for purely social support may be helpful. Clergy could opt into this and arrange social events in pairs or groups, or by activity, e.g., walking, film nights, or pub quizzes etc.
3. Institutional / organisational –
   a. As the COVID-19 lockdown created positives for some in relation to shorter Sundays, and increased time, a bank of self-paced smarter working modules may be beneficial.
   b. As some found the rapid change to online working during the lockdown challenging, skill building courses on contemporary issues and technology, e.g., X / Twitter, marketing using social media, or hosting online forums etc. may be beneficial.
   c. Formal self-care training modules should be made available at theological college to support new clergy entering ministry.
4. Christian community network –

a. There is a distinct lack of understanding from some congregants about the clergy role. Efforts need to be trialled to educate congregants on the support needed by clergy, their role demands, and how they can work together. Suggestions may be provided based on time availability, e.g., prayer or volunteering special skills etc. This perhaps could be included as part of church membership. For non-members, an annual ministerial focus day may be advantageous, akin to mission Sunday. Here clergy could discuss their role openly with the congregation, ask for support, prayer, and any other specific concerns as they see fit. This could be promoted and backed by the BUGB where there was a national day of celebration, thanksgiving, support, and prayer for ministerial teams incorporated into Sunday services.

b. As many clergy derive support from the wider Christian community, improved partnership with speakers, authors, and institutions may be beneficial. This could form part of CMD or could be engaged with on an informal level. A program of topics may beneficial, e.g., the challenge of practicing personal spirituality and leading spiritual practices corporately.

5. Societal / policy –

a. Clear health and wellbeing policy and guidelines for churches and individuals. The BUGB could produce a template document or an information pack framework to help with this,

housed on their website. Additionally, support sessions and webinars on putting it into practice may be useful.

b. As part of an improved health and wellbeing policy structure, better training on mental health would be advantageous. Some form of mental health first aid training would not only support clergy interactions with congregants, but would also promote better self-care in relation to this domain.

It is noted that improved occupational holistic self-care requires time to develop. With the Church of England strategy, however, it incorporates language such as ‘shift’, ‘towards’, and ‘change’, which suggest an active movement towards that change, not immediate success (Butler, 2019, pp. 5-6). Ergo, the overarching recommendation from this thesis’ key findings is to prompt a formal discussion between clergy, congregations, and support agencies. It is evident, from this thesis findings, that some Baptist clergy are experiencing health inequalities. Therefore, these findings and evidenced based recommendations should be used as a foundation for dialogue on how Baptist clergy can begin their own denomination specific ‘shift’ ‘towards’ positive ‘change’.

7.5 Contributions of this Research

This thesis has created new knowledge and made an important contribution to the research field. There is a distinct and significant gap in the UK clergy literature, as identified in Chapter two, which this thesis’ original research works have begun to fill. This thesis presents unique investigations, designed and implemented solely by the author, which are, to date, the first of their kind regarding UK Baptist clergy.

The first quantitative investigation offers valuable new knowledge to UK clergy research and a significant pioneering contribution to UK Baptist clergy research. This is the first UK clergy study of its kind, to date, (with the exception of elements of the unpublished Living Ministry Programme [The Church of England, n.d.-b]) to comprehensively examine holistic health and wellbeing using a broad range of tools and measures. This study has collected new clergy data on health components such as sleep quality, nutritional status, physical activity including strengthening, psychological supervision opportunities, and perceived permissions to self-care etc. in one questionnaire. Additionally, this study introduces the use of measures such as SWEMWBS, BNSQ-short, NPAQ- short, and WRRQ to clergy research, a further contribution to the international research field.

The second qualitative investigation was similarly pioneering. This work was again, the first of its kind, to date, in UK Baptist clergy research. It presents an in-depth exploration into the perceived barriers and facilitators to self-care. Again, due to the limited UK published research, this study adds a valuable contribution not only to Baptist specific research, but to the wider UK clergy research pool. As discussed in Chapter two, UK clergy research has largely been limited in scope, significantly lacking a holistic focus. This study presents a holistic investigation which most notably identified a critical understanding of the interrelated nature of health by clergy. This understanding of health within this cohort presents a significant foundation for future research development and justification for the necessity for holistic underpinning.

The first three studies of this thesis provided a rationale and foundation for the development of a groundbreaking UK Baptist clergy intervention. This pioneering holistic self-care intervention is the first of its kind, to date, administered

amongst UK Baptist clergy, and from the available published literature, the first holistic clergy self-care intervention administered in the UK. This intervention, solely designed and administered by the author, showed feasibility and / or acceptability in all 10 evaluation criteria (Gadke et al., 2021). In addition to showing suitability for the target group, the intervention demonstrated the potential to affect positive self-care behaviour change. This intervention, therefore, could now be piloted and rolled out full scale. Additionally, due to the novel nature of the intervention, this provides a robust foundation for future researchers to develop other large-scale clergy interventions both online and in person.

Despite the unforeseen global events of the PhD period, this thesis presents work that is contemporary, adaptive, and relevant to ministry in a rapidly changing world. The work presents sequential investigations which have used carefully applied techniques to map, explore and influence clergy holistic health and self-care behaviours.

In addition to the academic contributions, this work has made real world evidenced based recommendations suitable for review by clergy, churches, and support agencies at ground level. This thesis' works, like the works of authors Proeschold-Bell and Byassee (2018) and Proeschold-Bell et al. (2017) argues a deficit in clergy health against comparative populations. As such, this thesis most importantly presents evidence and provides an argument for new approaches to self-care in ministry.

7.6 Strengths and Limitations of this Thesis

The author as a registered medical professional, workplace health and wellbeing specialist, accredited trainer and higher education lecturer, and practicing

Christian, offers a unique position and strength in the work. The author was able to use their layered knowledge and skills to collect and analyse data, as well as communicate with and instruct clergy, designing research that is medically accurate, theologically conscious, and sensitive to adult knowledge assimilation. This amalgamation of knowledge and skills was essential when credibly communicating with gate keepers at the BU, individual clergy, and churches. Such access otherwise may not have been granted to differently skilled researchers.

As seen in socioecological modelling of holistic health, clergy do not live and work in a vacuum, their individual health is impacted by a myriad of variables from their differing environments. A limitation of this study was its focus on individual clergy. Now that this thesis work has broken ground in UK Baptist self-care research, future works may wish to consider broader exploration into clergy health as impacted by environment, e.g., size and location of church, those with supportive leadership teams, and those with congregant challenges.

A further limitation of this thesis is the historical period in which the works were undertaken. In addition to the impacts of COVID-19, and wider international political instability, the UK has suffered extreme austerity measures (exacerbated by COVID-19) which have significantly affected community resources (Arrieta, 2022; Blackburn, 2020; Trades Union Congress, 2023). These essential community resources are often interlinked with ministry roles, e.g., signposting to housing or mental health services. Excessive waiting lists or gaps in public services due to charity insolvency (Charity Commission for England and Wales, 2021) may have increased the pressure that clergy feel in relation to supporting their congregations. As previously discussed, Baptist churches are run as independent businesses, and as such the financial strain of COVID-19, plus the pre and post-austerity measures are

likely to have increased the pressure on individual churches and in turn their clergy. This type of additional role pressure may have had negative health and wellbeing effects which may have skewed results (in relation to ‘normal’ periods). Additionally, this may have potentially reduced the number of clergy willing to participate in non-essential research activities. Conversely, this may have attracted certain participants who wish to voice and vent their concerns. As the ongoing effects of the recent challenges are still being felt by many, this work offers a snapshot into clergy holistic health and self-care during times of crisis. This area, again is, to date, unexplored in UK Baptist clergy. The period in history is noted, however, the rich data in this thesis remains extremely valuable in a limited field.

The studies’ sample sizes may be seen as a limitation. As discussed here, and in the following section, the period in which the studies were carried out may have impacted participation rates, especially with regards to Study one. Additionally, as discussed in Chapter six, the low participation rate may be a symptom of time demands and could be viewed as data in its own right, although this would need to be investigated further in future research. Although larger samples may have been desirable from the outset, Study one’s sample provided sufficient data to compare with existing literature and the wider adult population. Enough data was collected in Study two to generate pertinent themes worthy of further exploration. Finally, Study four provided a suitable amount of data to determine feasibility and acceptability, showing 100% consensus for relevance and 91% agreement for prompting self-care change. Ergo, despite the smaller samples, the objectives in all studies were met.

7.7 COVID-19 Impact

The effects of COVID-19 significantly impacted this thesis at multiple stages. This thesis' first quantitative questionnaire was opened on 31st January 2020 and intended to be open for six months. UK COVID-19 restrictions spanned March 2020 to March 2021. This meant that the first two stages of data collection were conducted during unprecedented biopsychosocio-political periods. It is acknowledged that participation and the responses by participants may have been affected and may differ from that of 'normal' periods due to increased personal and occupational pressures.

The low participation rate in Study four is acknowledged and potentially partially attributed to the multifaceted ongoing and aftereffects of the period on individuals, families, churches, and communities. Evidence indicates that the UK lockdown measures had significant negative mental, financial, biological, social and behaviour impacts on citizens (Mind, 2021; Muehlschlegel et al., 2021; Vizard & Joloza, 2021). Although some negative mental health effects reverted to pre COVID-19 levels, women, and those in the most vulnerable populations, including the elderly, those with pre-existing mental health issues, and those on low income, experienced 'seesaw' prolonged effects (Office for Health Improvement Disparities, 2022). Ergo, it is highly likely that clergy will have worked with individuals in these vulnerable groups, adding to their occupational pressure.

7.8 Overall Conclusions

This thesis' investigations have explored for the first time, to date, UK Baptist clergy holistic health, wellbeing, and self-care behaviours. The works have highlighted specific health deficits in Baptist clergy against comparative adult

populations and produced similar results to that of other international clergy studies. Upon qualitative analysis, clergy report complex holistic self-care heavily influenced by their roles. Interviewed clergy reported prominent barriers to health, and a notable awareness and experience of the inter-relationship between their health facets. These findings provide a valuable contribution to the limited field of clergy occupational health and psychology. The systematised literature review further highlighted a significant gap in clergy health interventions. This review provided a solid foundation for Study four by collating key successful procedural elements from the limited available works. Finally, Study four offered a novel contribution to the UK clergy research field by detailing an acceptable, feasible and adaptable self-care intervention structure.

Overall, this thesis' findings have highlighted the need for industry changes in policy and practice at the individual, church, and support agency level. Additionally, the final intervention has provided a foundation and framework for future researchers to apply feasible and cohort acceptable holistic self-care interventions. Most notably, this thesis has broken ground on a new area of UK clergy self-care exploration. This thesis has highlighted the need for ongoing research in the field, and increased attention on the complex occupational health and wellbeing needs of these, often pivotal, community workers.

References

Abernethy, A. D., Grannum, G. D., Gordon, C. L., Williamson, R., & Currier, J. M. (2016). The pastors empowerment program: A resilience education intervention to prevent clergy burnout. *Spirituality in Clinical Practice, 3*(3), 175–186. https://doi.org/10.1037/scp0000109

Advance HE. (n.d.). *Advance HE*. https://www.advance-he.ac.uk/

Advisory, Conciliation and Arbitration Service. (2012). *Health, work and wellbeing* (Ref: B12). https://archive.acas.org.uk/media/854/Advisory-booklet---Health-Work-and-Wellbeing/pdf/Health-work-and-wellbeing-accessible-version.pdf

Advisory, Conciliation and Arbitration Service. (2023, March 23). *Working time rules: Being on call*. https://www.acas.org.uk/working-time-rules/employees-who-are-on-call-or-sleep-in

Adams, C. J., 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. https://doi.org/10.1007/s11089-016-0722-4

Adams, J. M. (2019). The value of worker well-Being. *Public Health Reports, 134*(6), 583-586. https://doi.org/10.1177%2F0033354919878434

Ajzen, I. (n.d.). *The theory of planned behavior: A bibliography.* https://people.umass.edu/aizen/tpbrefs.html

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50*(2), 179-211. https://doi.org/10.1016/0749-5978(91)90020-T

Ajzen, I. (2012). The theory of planned behavior. In Van Lange, P. A. M., Kruglanski, A. W., & Higgins, E. T. (Eds.), *The Handbook of Theories of Social Psychology: Volume 1* (pp. 438-459). SAGE.

Ajzen, I. (2020). The theory of planned behavior: Frequently asked questions. *Human Behavior and Emerging Technologies, 2*(4), 314-324. https://doi.org/10.1002/hbe2.195

Alexander, G. K., Rollins, K., Walker, D., Wong, L., & Pennings, J. (2015). Yoga for self-care and burnout prevention among nurses. *Workplace Health & Safety, 63*(10), 462-470. https://doi.org/10.1177/2165079915596102

Allen Jr, J. S., Tarnowski, K. J., Simonian, S. J., Elliott, D., & Drabman, R. S. (1991). The Generalization Map revisited: Assessment of generalized

treatment effects in child and adolescent behavior therapy. *Behavior Therapy, 22*(3), 393-405. https://doi.org/10.1016/S0005-7894(05)80373-9

Allergy UK. (n.d.). *Statistics and figures: Allergy prevalence: Useful facts and figures* [Data summary]. https://www.allergyuk.org/about-allergy/statistics-and-figures/

Andover Baptist Church. (n.d.). *Senior minister role* [Job description]. Retrieved November 28, 2019, from https://www.andoverbaptist.org.uk/downloads/ABC-Senior-Minister-Job-Description.pdf

Antoni, M. H. (2003). Stress management effects on psychological, endocrinological, and immune functioning in men with HIV infection: empirical support for a psychoneuroimmunological model. *Stress, 6*(3), 173-188. https://doi.org/10.1080/1025389031000156727

Arain, M., Campbell, M. J., Cooper, C. L., & Lancaster, G. A. (2010). What is a pilot or feasibility study? A review of current practice and editorial policy. *BMC Medical Research Methodology, 10*, Article 67. https://doi.org/10.1186/1471-2288-10-67

Arber, S., Fenn, K., & Meadows, R. (2014). Subjective financial well-being, income and health inequalities in mid and later life in Britain. *Social Science & Medicine, 100*, 12-20. https://doi.org/10.1016/j.socscimed.2013.10.016

Arden, M. A., & Armitage, C. J. (2008). Predicting and explaining transtheoretical model stage transitions in relation to condom-carrying behaviour. *British Journal of Health Psychology, 13*(4), 719-735. https://doi.org/10.1348/135910707X249589

Arrieta, T. (2022). Austerity in the United Kingdom and its legacy: Lessons from the COVID-19 pandemic. *The Economic and Labour Relations Review, 33*(2), 238-255. https://doi.org/10.1177/10353046221083051

Arruñada, B. (2010). Protestants and Catholics: Similar work ethic, different social ethic. *The Economic Journal, 120*(547), 890-918. https://dx.doi.org/10.2139/ssrn.1397223

Backus, L. (2013). *Sanctification of work: A potential moderator of the relationship between work stress and health* [Doctoral dissertation, Bowling Green State University]. OhioLink.

https://etd.ohiolink.edu/apexprod/rws_etd/send_file/send?accession=bgsu1363199031&disposition=inline

Bailey, R. R. (2019). Goal setting and action planning for health behavior change. *American Journal of Lifestyle Medicine, 13*(6), 615-618. https://doi.org/10.1177%2F1559827617729634

Bakker, A. B., & Demerouti, E. (2007). The job demands-resources model: State of the art. *Journal of Managerial Psychology*, *22*(3), 309-328. https://doi.org/10.1108/02683940710733115

Ballinger, C. (2004). Writing up rigour: Representing and evaluating good scholarship in qualitative research. *British Journal of Occupational Therapy, 67*(12), 540-546. https://doi.org/10.1177/030802260406701204

Baptists Together. (n.d.-a). *Ministry.* https://www.baptist.org.uk/Groups/347472/Ministry.aspx

Baptists Together. (n.d.-b). *Online directory: Ministries*. https://www.baptist.org.uk/Articles/504943/Ministries.aspx

Baptists Together. (n.d.-c). *Who are Baptists?* https://www.baptist.org.uk/Groups/220484/Who_are_Baptists.aspx

Baptists Together. (2011, February). *Guide to pastoral practice and ministry* [Organisational guidelines]. https://www.baptist.org.uk/Publisher/File.aspx?ID=111427&view=downloa

Baptists Together. (2013, July). *Knowing what we believe* [Organisational guidelines]. https://www.baptist.org.uk/Publisher/File.aspx?ID=111289&view=browser

Baptists Together. (2016). *Baptist basics: 8 leadership in the local church* [Fact sheet]. https://www.baptist.org.uk/Articles/464308/Baptist_Basics_8.aspx

Baptists Together. (2019). *BUGB churches were asked to supply us with the current average attendance at their main weekly service of worship 2019* [Data set]. https://www.baptist.org.uk/Publisher/File.aspx?ID=258731

Baptists Together. (2021a). *Annual church statistics report 2021* [Data set]. https://www.baptist.org.uk/Publisher/File.aspx?ID=305508

Baptists Together. (2021b). *Continuing ministerial development* [Organisational guidelines]. https://www.baptist.org.uk/Articles/589058/CMD_Handbook.aspx

Baptists Together. (2023). *CMD: Accessing and practising mentoring*,

pastoral supervision and spiritual direction. https://baptist.org.uk/Publisher/File.aspx?ID=309349&view=download

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). In pursuit of wellness: The self-care imperative. *Professional Psychology: Research and Practice, 38*(6), 603-612. https://doi.org/10.1037/0735-7028.38.6.603

Barr-Walker, J. (2017). Evidence-based information needs of public health workers: a systematized review. *Journal of the Medical Library Association, 105*(1), 69-79. https://doi.org/10.5195/jmla.2017.109

Bayley, J., Brown, K., & Wallace, L. (2009). Teenagers and emergency contraception in the UK: A focus group study of salient beliefs using concepts from the theory of planned behaviour. *The European Journal of Contraception & Reproductive Health Care, 14*(3), 196-206. https://doi.org/10.1080/13625180902741444

Beebe, R. S. (2007). Predicting burnout, conflict management style, and turnover among clergy. *Journal of career assessment, 15*(2), 257-275. https://doi.org/10.1177/1069072706298157

Bennet, L., & Lindström, M. (2018). Self-rated health and social capital in Iraqi immigrants to Sweden: The MEDIM population-based study. *Scandinavian Journal of Public Health, 46*(2), 194-203. https://doi.org/10.1177/1403494817730997

Beresin, E. V., Milligan, T. A., Balon, R., Coverdale, J. H., Louie, A. K., & Roberts, L. W. (2016). Physician wellbeing: a critical deficiency in resilience education and training. *Academic Psychiatry, 40*(1), 9–12. https://doi.org/10.1007/s40596-015-0475-x

Berry, A., Francis, L. J., Rolph, J., & Rolph, P. (2012). Ministry and stress: Listening to Anglican clergy in Wales. *Pastoral Psychology, 61*(2), 165-178. https://doi.org/10.1007/s11089-011-0388-x

Beverley Baptist Church. (n.d.). *Our team: Responsibilities of the leadership team* [Organisational website]. https://www.beverleybaptist.com/about/team/

Blackburn Baptist Church. (n.d.). *Pastor: Blackburn Baptist church job specification* [Job description]. Retrieved November 28, 2019, from https://ninethirtyeight.org/userfiles/file/opportunities/Blackburn%20BC%20Pastor.pdf

Blackburn, P. (2020, October 8). *Austerity: COVID's little helper*. British Medical Association. https://www.bma.org.uk/news-and-opinion/austerity-covid-s-little-helper

Bodine, P. A., Mothapo, N. P., & Reardon, K. (2021). 3-Step charrette: A framework for teaching students to solve complex problems in a real-world environment. *Management Teaching Review*, *6*(1), 37-65. https://doi.org/10.1177%2F2379298119855704

Bolier, L., Haverman, M., Westerhof, G. J., Riper, H., Smit, F., & Bohlmeijer, E. (2013). Positive psychology interventions: A meta-analysis of randomized controlled studies. *BMC Public Health, 13,* Article 119. https://doi.org/10.1186/1471-2458-13-119

Booth, A., Noyes, J., Flemming, K., Moore, G., Tunçalp, Ö., & Shakibazadeh, E. (2019). Formulating questions to explore complex interventions within qualitative evidence synthesis. *BMJ Global Health, 4,* Article e001107. https://doi.org/10.1136%2Fbmjgh-2018-001107

Bopp, M., Baruth, M., Peterson, J. A., & Webb, B. L. (2013). Leading their flocks to health?: Clergy health and the role of clergy in faith-based health promotion interventions. *Family and Community Health, 36*(3), 182-192. https://doi.org/10.1097/FCH.0b013e31828e671c

Bosnjak, M., Ajzen, I., & Schmidt, P. (2020). The theory of planned behavior: Selected recent advances and applications. *Europe's Journal of Psychology, 16(*3), 352-356. https://doi.org/10.5964%2Fejop.v16i3.3107

Bowen, D. J., Kreuter, M., Spring, B., Cofta-Woerpel, L., Linnan, L., Weiner, D., Bakken, S., Kaplan, C. P., Squires, L., Fabrizio, C., & Fernandez, M. (2009). How we design feasibility studies. *American Journal of Preventive Medicine, 36*(5), 452-457. https://doi.org/10.1016/j.amepre.2009.02.002

Bradburn, N. M. (1969). *The structure of psychological well-being.* Aldine. https://archive.org/details/structureofpsych0000brad/page/n7/mode/2up

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Braun, V., & Clarke, V. (2019a). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589-597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2019b). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health, 13*(2), 201-216. https://doi.org/10.1080/2159676X.2019.1704846

Braun, V., Clarke, V., & Hayfield, N. (2022). 'A starting point for your journey, not a map': Nikki Hayfield in conversation with Virginia Braun and Victoria Clarke about thematic analysis. *Qualitative Research in Psychology, 19*(2), 424-445. https://doi.org/10.1080/14780887.2019.1670765

British Heart Foundation. (n.d.). *What does BMI mean?* https://extras.bhf.org.uk/patientinfo/bmi-v1.01/app/index.html

Brownback, L. (2019, January 18). The danger of self-care. *Crossway.* https://www.crossway.org/articles/the-danger-of-self-care/

Bullock, A. N., Colvin, A. D., & Jackson, M. S. (2022). "All zoomed out": strategies for addressing zoom fatigue in the Age of COVID-19. In *Innovations in Learning and Technology for the Workplace and Higher Education: Proceedings of 'The Learning Ideas Conference' 2022*, (Vol. 1, pp. 61-68). Springer International Publishing. https://doi.org/10.1007/978-3-030-90677-1_6

Burnard, P. (1991). A method of analysing interview transcripts in qualitative research. *Nurse education today, 11*(6), 461-466. https://doi.org/10.1016/0260-6917(91)90009-Y

Butler, S. (2019). *General synod: A covenant for clergy care and wellbeing* (GS 2133). The Church of England. https://www.churchofengland.org/sites/default/files/2019-06/GS%202133%20A%20Covenant%20for%20Clergy%20Care%20and%20Wellbeing.pdf

Butler, S. (2020). *Covenant for clergy care and wellbeing.* https://www.churchofengland.org/resources/clergy-resources/national-clergy-hr/supporting-clergy-health-and-wellbeing/covenant#na

Bux, S. M., & Coyne, S. M. (2009). The effects of terrorism: The aftermath of the London terror attacks. *Journal of Applied Social Psychology*, *39*(12), 2936-2966. https://doi.org/10.1111/j.1559-1816.2009.00556.x

Calculator.net. (n.d.). *Sample size calculator*. https://www.calculator.net/sample-size-calculator.html

Cantuar, J., & Ebor, S. (2020). *The general synod of the Church of England: The clergy covenant for wellbeing act of synod 2020.* https://www.churchofengland.org/sites/default/files/2020-07/Act%20of%20Synod%20instrument.pdf

Care Act 2014, Chapter 23 § 1 (2014). https://www.legislation.gov.uk/ukpga/2014/23/section/2/enacted

Case, A. D., Keyes, C. L., Huffman, K. F., Sittser, K., Wallace, A., Khatiwoda, P., Parnell, H. E., & Proeschold-Bell, R. J. (2020). Attitudes and behaviors that differentiate clergy with positive mental health from those with burnout. *Journal of Prevention & Intervention in the Community, 48*(1), 94-112. https://doi.org/10.1080/10852352.2019.1617525

Chandler, D. J. (2009). Pastoral burnout and the impact of personal spiritual renewal, rest-taking, and support system practices. *Pastoral Psychology*, *58*(3), 273-287. https://doi.org/10.1007/s11089-008-0184-4

Chaparro, M. P., Hughes, A., Kumari, M., & Benzeval, M. (2019). Is the association between self-rated health and underlying biomarker levels modified by age, gender, and household income? Evidence from Understanding Society–the UK Household Longitudinal Study. *SSM-Population Health, 8*, Article 100406. https://doi.org/10.1016/j.ssmph.2019.100406

Charity Commission for England and Wales. (2021). *Charity commission COVID-19 survey 2021* [Data summary]. https://www.gov.uk/government/publications/charity-commission-covid-19-survey-2021/covid-19-survey-2021

Cherry, M. G., & Dickson, R. (2017). Defining my review question and identifying inclusion and exclusion criteria. In Boland, A., Cherry, M. G., & Dickson, R. (Ed.), *Doing a systematic review: A student's guide* (2nd ed., pp. 43-59). SAGE.

Churches Ministerial Counselling Service. (n.d.). *Eligibility details: Baptist Union of Great Britain.* https://www.cmincs.net/eligibilitydetails.htm#BUGB

Church of the Nazarene. (2017). *Pastor Yedam Church of the Nazarene* [Job description]. Retrieved November 28, 2019, from http://nazarene.org.uk/images/vacancies/Yedam_Pastoral_Vacancy.pdf

Ciaunica, A., McEllin, L., Kiverstein, J., Gallese, V., Hohwy, J., & Woźniak, M. (2021). Zoomed out? Depersonalization is related to increased digital media use during the COVID-19 pandemic lockdown. *PsyArXiv Preprints,* Article PPR397830. https://doi.org/10.31234/osf.io/8jver

Clarke, M. A., Walker, K. D., Spurr, S., & Squires, V. (2022). Clergy resilience: Accessing supportive resources to balance the impact of role-related stress and adversity. *Journal of Pastoral Care & Counseling, 76*(3), 210-223. https://doi.org/10.1177/15423050221090864

Cleveland Clinic. (2020, November 4). *Which bread is best for you: Whole-grain, multigrain or whole wheat?* https://health.clevelandclinic.org/bread-best-whole-grain-multigrain-whole-wheat/

Clift, S. (2018). *Clergy wellbeing* (GCWB(18)5). The Church of England. https://www.churchofengland.org/sites/default/files/2018-10/GCWB%2818%295%20revd%20-%20s%20clift%20.pdf

Clinton, M. E., Conway, N., & Sturges, J. (2017). "It's tough hanging-up a call": The relationships between calling and work hours, psychological detachment, sleep quality, and morning vigor. *Journal of Occupational Health Psychology, 22*(1), 28-39. https://doi.org/10.1037/ocp0000025

Clinton, M., & Frasca, K. (2017). *Experiences of ministry 2017: Main findings report* [Unpublished internal report]. King's Business School, King's College London on behalf of the National Continuing Ministry Development Panel.

Clinton, M. & Ling, T. (2017). *Effective ministerial presence and what it looks like in practice: Insights from the experiences of ministry project 2011–17.* King's Business School & The Church of England. https://www.churchofengland.org/sites/default/files/2017-10/experience_of_ministry_survey.pdf

Conway, N., Clinton, M., Sturges, J., & Budjanovcanin, A. (2015). Using self-determination theory to understand the relationship between calling enactment and daily well-being. *Journal of Organizational Behavior, 36*(8), 1114-1131. https://doi.org/10.1002/job.2014

Cook, C. C. (2020). Spirituality, religion & mental health: exploring the boundaries. *Mental Health, Religion & Culture, 23*(5), 363-374. https://doi.org/10.1080/13674676.2020.1774525

Coolican, H. (2006). *Introduction to research methods in psychology*. Hodder Arnold.

Coolican, H. (2019). *Research methods and statistics in psychology*. Routledge.

Cowper, G. L. (2012). *An analysis of the relationship between physical exercise and the spiritual life of clergy* [Doctoral dissertation, Gordon-Conwell Theological Seminary]. Amazon.

CREDO Institute. (2006). *Episcopal clergy wellness: A report to the church on the state of clergy wellness, June 2006.* [Internal unpublished research report]. https://www.cpg.org/globalassets/documents/publications/credo-clergy-wellness-report.pdf

Cropley, M. (2015). *The off switch*. Penguin Random House.

Cropley, M., & Collis, H. (2020). The association between work-related rumination and executive function using the behavior rating inventory of executive function. *Frontiers in Psychology, 11*, Article 821. https://doi.org/10.3389%2Ffpsyg.2020.00821

Cropley, M., Michalianou, G., Pravettoni, G., & Millward, L. J. (2012). The relation of post-work ruminative thinking with eating behaviour. *Stress and Health, 28*(1), 23-30. https://doi.org/10.1002/smi.1397

Cropley, M., Zijlstra, F. R., Querstret, D., & Beck, S. (2016). Is work-related rumination associated with deficits in executive functioning? *Frontiers in Psychology, 7*, Article 1524. https://doi.org/10.3389%2Ffpsyg.2016.01524

Cummings, J. P., & Pargament, K. I. (2010). Medicine for the spirit: Religious coping in individuals with medical conditions. *Religions, 1*(1), 28-53. https://doi.org/10.3390/rel1010028

Cuthbert, A. D., Davis, E. B., Aten, J. D., Short, A., Yarborough, C. A., Lavelock, C. R., Worthington, E. L., Jr., Davis, D. E., Hook, J. N., & Van Tongeren, D. R. (2018). Cultivating humility in religious leaders: The effectiveness of a spiritually integrated positive psychology intervention. *Spirituality in Clinical Practice, 5*(4), 227–239. https://doi.org/10.1037/scp0000185

Cutts, T. F., Gunderson, G. R., Proeschold-Bell, R. J., & Swift, R. (2012). The life of leaders: An intensive health program for clergy. *Journal of Religion and Health, 51*(4), 1317-1324. https://doi.org/10.1007/s10943-010-9436-6

Dalgaard, L., Eskildsen, A., Carstensen, O., Willert, M. V., Andersen, J. H., & Glasscock, D. J. (2014). Changes in self-reported sleep and cognitive failures: A randomized controlled trial of a stress management intervention. *Scandinavian Journal of Work, Environment & Health, 40*(6), 569-581. https://doi:10.5271/sjweh.3460

Dankasa, J. (2015). Information-seeking behavior of clergy: The research, the results, and the future. *Journal of Religious & Theological Information, 14*(1-2), 13-29. https://doi.org/10.1080/10477845.2015.1035196

Danquah, I. H., Petersen, C. B., Skov, S. S., & Tolstrup, J. S. (2018). Validation of the NPAQ-short–A brief questionnaire to monitor physical activity and compliance with the WHO recommendations. *BMC Public Health, 18*, Article 601. https://doi.org/10.1186/s12889-018-5538-y

Darling, C. A., Hill, E. W., & McWey, L. M. (2004). Understanding stress and quality of life for clergy and clergy spouses. *Stress and Health, 20*(5), 261-277. https://doi.org/10.1002/smi.1031

Darnell, S. C., Chawansky, M., Marchesseault, D., Holmes, M., & Hayhurst, L. (2018). The state of play: Critical sociological insights into recent 'sport for development and peace' research. *International Review for the Sociology of Sport, 53*(2), 133-151. https://doi.org/10.1177/1012690216646762

Davis, B. G. (2011). *Preventing clergy burnout: Assessing the value of a mindfulness-based intervention as part of a holistic clergy wellness program* (Publication No. 3437455) [Doctoral dissertation, Chestnut Hill College]. Proquest Dissertations and Theses Global. https://www.proquest.com/openview/2851f7ef6ce5ad58bf816d7a7a834da5/1?pq-origsite=gscholar&cbl=18750

Day, K., & Petrakis, M. (2017). Family interventions in early psychosis service delivery: A systematized review. *Social Work in Mental Health, 15*(6), 632-650. https://doi.org/10.1080/15332985.2016.1271381

Day, T., & Tosey, P. (2011). Beyond SMART? A new framework for goal setting. *The Curriculum Journal, 22*(4), 515-534. https://doi.org/10.1080/09585176.2011.627213

Dein, S., & Cook, C. C. (2015). God put a thought into my mind: The charismatic Christian experience of receiving communications from God. *Mental Health, Religion & Culture, 18*(2), 97-113. https://doi.org/10.1080/13674676.2014.1002761

Dein, S., Cook, C. C., Powell, A., & Eagger, S. (2010). Religion, spirituality and mental health. *The Psychiatrist, 34*(2), 63-64. https://doi.org/10.1192/pb.bp.109.025924

Delgadillo, J., Saxon, D., & Barkham, M. (2018). Associations between therapists' occupational burnout and their patients' depression and anxiety treatment outcomes. *Depression and Anxiety, 35*(9), 844-850. https://doi.org/10.1002/da.22766

Del Rosario, M. (2014, January 28). 7 key differences between protestant and catholic doctrine. *Voice Dallas Seminary.* https://voice.dts.edu/article/7-key-differences-between-protestant-and-catholic-doctrine-del-rosario-mikel/

De Man, J., Campbell, L., Tabana, H., & Wouters, E. (2021). The pandemic of online research in times of COVID-19. *BMJ Open, 11*(2), Article e043866. https://doi:10.1136/bmjopen-2020-043866

Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The job demands-resources model of burnout. *Journal of Applied Psychology, 86*(3), 499 -512. https://doi:101037//0021-9010863499

Demerouti, E., Bakker, A. B., Vardakou, I., & Kantas, A. (2003). The convergent validity of two burnout instruments: A multitrait-multimethod analysis. *European Journal of Psychological Assessment, 19*(1), 12-23. https://psycnet.apa.org/doi/10.1027/1015-5759.19.1.12

Demerouti, E., Mostert, K., & Bakker, A. B. (2010). Burnout and work engagement: A thorough investigation of the independency of both constructs. *Journal of Occupational Health Psychology, 15*(3), 209-222. https://doi:10.1037/a0019408

Department of Health. (2013). *Wellbeing and Health* [Organisational guidelines]. https://www.gov.uk/government/publications/wellbeing-and-health

Department of Health. (2014). *Living well for longer: National support for local action to reduce premature avoidable mortality* (PHD/ IHPHPS/ RAMP/12341) [Government policy].

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/307703/LW4L.pdf

Department of Health and Social Care. (2019). *UK chief medical officers' physical activity guidelines* [Government guidelines]. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832868/uk-chief-medical-officers-physical-activity-guidelines.pdf

Deslandes, A., Moraes, H., Ferreira, C., Veiga, H., Silveira, H., Mouta, R., Pompeu, F. A. M. S., Coutinho, E. S. F., & Laks, J. (2009). Exercise and mental health: Many reasons to move. *Neuropsychobiology, 59*(4), 191-198. https://doi.org/10.1159/000223730

Dettmers, J., Vahle-Hinz, T., Bamberg, E., Friedrich, N., & Keller, M. (2016). Extended work availability and its relation with start-of-day mood and cortisol. *Journal of Occupational Health Psychology, 21*(1), 105-118. https://doi.org/10.1037/a0039602

Diocese of Ely. (2022, August 17). *Clergy wellbeing survey 2019*. https://www.elydiocese.org/church-roles/parish-clergy/clergy-wellbeing/clergy-wellbeing-8961.php

Doehring, C. (2013). New directions for clergy experiencing stress: Connecting spirit and body. *Pastoral Psychology, 62*(5), 623-638. https://doi.org/10.1007/s11089-013-0512-1

Dodgson, J. E. (2019). Reflexivity in qualitative research. *Journal of Human Lactation, 35*(2), 220-222. https://doi.org/10.1177/0890334419830990

Donald, G. (2018). A brief summary of pilot and feasibility studies: Exploring terminology, aims, and methods. *European Journal of Integrative Medicine, 24*, 65-70. https://doi.org/10.1016/j.eujim.2018.10.017

Doolittle, B. R. (2007). Burnout and coping among parish-based clergy. *Mental Health, Religion & Culture, 10*(1), 31-38. https://doi.org/10.1080/13674670600857591

Doran, G. T. (1981). There's a S.M.A.R.T. way to write management's goals and objectives. *Management Review, 70*(11), 35-36. https://community.mis.temple.edu/mis0855002fall2015/files/2015/10/S.M.A.R.T-Way-Management-Review.pdf

Dowson, M., & Miner, M. (2015). Interacting religious orientations and personal well-being among Australian church leaders. *Mental Health, Religion & Culture, 18*(1), 72-84. https://doi.org/10.1080/13674676.2014.1003167

Duke Divinity School. (n.d.-a). *Initiatives: Clergy health initiative.* https://divinity.duke.edu/initiatives/clergy-health-initiative

Duke Divinity School. (n.d.-b) *Clergy health initiative: What we're learning.* https://divinity.duke.edu/initiatives/clergy-health-initiative/learning#research

Duke Divinity School. (2019). *Clergy health initiative summary report: 2019 statewide survey of United Methodist clergy in North Carolina* [Data summary]. https://divinity.duke.edu/sites/divinity.duke.edu/files/documents/chi/2019%20Clergy%20Health%20Initiative%20Summary%20Report%20%E2%80%94%20Update.pdf

Duke University. (2018). *Scholars @ Duke: Rae Jean Proeschold-Bell*. https://scholars.duke.edu/person/rae.jean

Edmondson, R. (2015, June 8). 16 often unknown roles of a pastor. *Ministry Matters*. https://www.ministrymatters.com/all/entry/6087/16-often-unknown-roles-of-a-pastor

Edwards, L., Bretherton, R., Gresswell, D. M., & Sabin-Farrell, R. (2020). The relationship between social support, spiritual well-being, and depression in Christian clergy: a systematic literature review. *Mental Health, Religion & Culture, 23*(10), 857-873. https://doi.org/10.1080/13674676.2020.1838459

Edwards, L., Bretherton, R., Gresswell, D. M., & Sabin-Farrell, R. (2023). Psychological distress, coping, and barriers to help-seeking in Christian clergy. *Mental Health, Religion & Culture, 25*(10), 956-973. https://doi.org/10.1080/13674676.2022.2117292

Edwards, L., Sabin-Farrell, R., Bretherton, R., Gresswell, D. M., & Tickle, A. (2022). “Jesus got crucified, why should we expect any different?”; UK Christian clergies’ experiences of coping with role demands and seeking support. *Mental Health, Religion & Culture, 25*(4), 462-478. https://doi.org/10.1080/13674676.2022.2059068

Elders, K. L. (2010). *A fitness model for pastors* [Doctoral dissertation, Liberty Baptist Theological Seminary]. Liberty University ProQuest Dissertations Publishing.

https://www.proquest.com/openview/7184adab721176b3e4825697ff061c50/1?pq-origsite=gscholar&cbl=18750

Elmhurst University. (n.d.). *Defining goals* [Work sheet]. https://www.elmhurst.edu/wp-content/uploads/2021/07/elmhurst-unversity-wcpe-smart-goals-action-plan-2021-22.pdf

Emmons, B. L. (2015). *Holistic health in the ministry: A model for physical and spiritual health for middle aged Pentecostal pastors* [Doctoral dissertation, Regent University]. Regent University ProQuest Dissertations Publishing. https://www.proquest.com/docview/1728124982

Espedido, A., Searle, B. J., & Griffin, B. (2019). Peers, proactivity, and problem-solving: A multilevel study of team impacts on stress appraisals of problem-solving demands. *Work & Stress, 34*(3), 219-237. https://doi.org/10.1080/02678373.2019.1579767

European Social Survey European Research Infrastructure (ESS ERIC). (2018). *ESS5 data documentation*. Sikt - Norwegian Agency for Shared Services in Education and Research. https://doi.org/10.21338/NSD-ESS5-2010

European Social Survey European Research Infrastructure (ESS ERIC). (2021). *ESS round 9 - 2018. Timing of life, justice and fairness: ESS9 - integrated file, edition 3.1* [Data set]. Sikt - Norwegian Agency for Shared Services in Education and Research. https://doi.org/10.21338/ESS9E03_1

Evangelical Alliance. (2020). *Changing Church: Responding to the Coronavirus crisis.* https://www.eauk.org/assets/files/downloads/Changing-church-Responding-to-the-coronavirus-crisis.pdf

Evangelical Lutheran Church in America. (2002, December 4). *ELCA Studies the health and wellness of its ministers.* https://www.elca.org/News-and-Events/4542

Evers, W., & Tomic, W. (2003). Burnout among Dutch reformed pastors. *Journal of Psychology and Theology, 31*(4), 329-338. https://doi.org/10.1177/009164710303100403

Eyre, E. L., Adeyemi, L. J., Cook, K., Noon, M., Tallis, J., & Duncan, M. (2022). Barriers and facilitators to physical activity and FMS in children living in deprived areas in the UK: Qualitative study. *International Journal of Environmental Research and Public Health, 19*(3), Article 1717. https://doi.org/10.3390/ijerph19031717

Faith Survey. (2022, September 8). *Christianity in the UK, measuring the Christian population in the UK: UK Christianity (2005-2025).* https://faithsurvey.co.uk/uk-christianity.html

Farrell, A. E. (2001). *Fat shame: Stigma and the fat body in American culture*. NYU Press.

Faucett, J. M., Corwyn, R. F., & Poling, T. H. (2013). Clergy role stress: Interactive effects of role ambiguity and role conflict on intrinsic job satisfaction. *Pastoral Psychology, 62*(3), 291-304. https://doi.org/10.1007/s11089-012-0490-8

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research, 12*(4), 531-545. https://doi.org/10.1177/104973202129120052

Firoozabadi, A., Uitdewilligen, S., & Zijlstra, F. R. H. (2018). Should you switch off or stay engaged? The consequences of thinking about work on the trajectory of psychological well-being over time. *Journal of Occupational Health Psychology, 23*(2), 278-288. https://doi.org/10.1037/ocp0000068

Fisher, J. (2010). Development and application of a spiritual well-being questionnaire called SHALOM. *Religions, 1*(1), 105-121. https://doi:10.3390/rel1010105

Fisher, J. (2012). Staff's and family members' spiritual well-being in relation to help for residents with dementia. *Journal of Nursing Education and Practice, 2*(4), 77-85. https://doi.org/10.5430/jnep.v2n4p77

Fisher, J. (2014). *The importance of relating with God for spiritual well-being* [Doctoral dissertation, University of Ballarat]. CORE by The Open University digital archive. https://core.ac.uk/download/pdf/213009454.pdf

Fisher, J., & Brumley, D. (2008). Nurses' and carers' spiritual wellbeing in the workplace. *The Australian Journal of Advanced Nursing, 25*(4), 49-57. https://search.informit.org/doi/10.3316/INFORMIT.210173636815527

Fisher, J. W., & Brumley, D. (2012). Palliative care doctors need help with spiritual wellbeing. *Journal for the Study of Spirituality, 2*(1), 49-60. https://doi.org/10.1558/jss.v2i1.49

Fisher, J. W., Francis, L. J., & Johnson, P. (2000). Assessing spiritual health via four domains of spiritual wellbeing: The SH4DI. *Pastoral Psychology, 49*(2), 133-145. https://doi.org/10.1023/A:1004609227002

Francis, L. J., Hills, P., & Rutledge, C. J. (2008). Clergy work-related satisfactions in parochial ministry: The influence of personality and churchmanship. *Mental Health, Religion and Culture, 11*(3), 327-339. http://dx.doi.org/10.1080/13674670701288639

Francis, L. J., Lankshear, D. W., & Robbins, M. (2011a). Psychological types of female primary school teachers in Anglican state-maintained schools in England and Wales: Implications for continuing professional development. *Research in Education, 86*(1), 13-24. https://doi.org/10.7227/RIE.86.2

Francis, L. J., Laycock, P., & Brewster, C. (2017a). Exploring the factor structure of the Francis psychological type scales among a sample of Anglican clergy in England. *Mental Health, Religion & Culture, 20*(9), 930-941. https://doi.org/10.1080/13674676.2017.1375469

Francis, L., Laycock, P., & Brewster, C. (2017b). Work-related psychological wellbeing: Testing the balanced affect model among Anglican clergy. *Religions, 8*(7), 118-128. https://doi.org/10.3390/rel8070118

Francis, L. J., Laycock, P., & Ratter, H. (2019). Testing the Francis burnout inventory among Anglican clergy in England. *Mental Health, Religion & Culture, 22*(10), 1057-1067. https://doi.org/10.1080/13674676.2019.1644304

Francis, L. J., & Robbins, M. (2002). Psychological types of male evangelical church leaders. *Journal of Beliefs and Values, 23*(2), 217-220. https://doi.org/10.1080/1361767022000010860

Francis, L. J., Robbins, M., & Wulff, K. (2013). Assessing the effectiveness of support strategies in reducing professional burnout among clergy serving in the Presbyterian Church (USA). *Practical Theology, 6*(3), 319-331. https://doi.org/10.1179/1756073X13Z.00000000021

Francis, L. J., & Rodger, R. (1994). The influence of personality on clergy role prioritization, role influences, conflict and dissatisfaction with ministry. *Personality and Individual Differences, 16*(6), 947-957. https://doi.org/10.1016/0191-8869(94)90237-2

Francis, L. J., Whinney, M., Burton, L., & Robbins, M. (2011b). Psychological type preferences of male and female free church ministers in England. *Research in the Social Scientific Study of Religion, 22*, 251-263. https://doi.org/10.1163/ej.9789004207271.i-360.55

Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues, 30*(1), 159-165. https://doi.org/10.1111/j.1540-4560.1974.tb00706.x

Fuller, L. K. (2018). In defense of self-care. *Journal of Pastoral Theology*, *28*(1), 5-21. https://doi.org/doi:10.1080/10649867.2018.1459106

Gadke, D. L., Kratochwill, T. R., & Gettinger, M. (2021). Incorporating feasibility protocols in intervention research. *Journal of School Psychology, 84*, 1-18. https://doi.org/10.1016/j.jsp.2020.11.004

Galesic, M., & Bosnjak, M. (2009). Effects of questionnaire length on participation and indicators of response quality in a web survey. *Public Opinion Quarterly, 73*(2), 349-360. https://doi.org/10.1093/poq/nfp031

Garland, G., & Village, A. (2022). Psychological type profiles and temperaments of ministers in the Baptist Union of Great Britain (BUGB). *Mental Health, Religion & Culture, 25*(9), 860-874. https://doi.org/10.1080/13674676.2021.1908974

Gibbs, G. (1988). *Learning by doing: A guide to teaching and learning methods.* Further Education Unit.

Giles, K., & Dyas, D. (2021). *COVID-19, Churches & communities: A church for the nation; a church for the future.* University of York. https://churchesandcovid.org/sites/churchesandcovid.org/files/2021-08/church-for-nation-community-report.pdf

Giusto, A., Vander Missen, M. R., Kosgei, G., Njiriri, F., Puffer, E., Kamaru Kwobah, E., Barasa, J., Turissini, M., Rasmussen, J., Ott, M., Binayo, J., Rono, W., & Jaguga, F. (2023). Peer-delivered problem-solving therapy for adolescent mental health in Kenya: Adaptation for context and training of peer-counselors. *Research on Child and Adolescent Psychopathology, 51*, 1243–1256. https://doi.org/10.1007/s10802-023-01075-8

Godman, H. (2021, September 1). *How many fruits and vegetables do we really need?* Harvard Health. https://www.health.harvard.edu/nutrition/how-many-fruits-and-vegetables-do-we-really-need

Gough, B., & Madill, A. (2012). Subjectivity in psychological science: From problem to prospect. *Psychological Methods, 17*(3), 374-384. https://doi.org/10.1037/a0029313

Grant, B. M., & Giddings, L. S. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse, 13*(1), 10-28. https://doi.org/10.5172/conu.13.1.10

Grant, M. J., & Booth, A. (2009). A typology of reviews: An analysis of 14 review types and associated methodologies. *Health Information & Libraries Journal, 26*(2), 91-108. https://doi.org/10.1111/j.1471-1842.2009.00848.x

Graveling, L. (n.d.). *Insights from recent research on clergy wellbeing* [PowerPoint slides]. https://www.churchofengland.org/sites/default/files/2020-10/Clergy%20Study%20Day%20updated_0.pdf

Graveling, L. (2018a). *Living ministry: Negotiating wellbeing: Experiences of ordinands and clergy in the Church of England.* https://www.churchofengland.org/sites/default/files/2018-10/Living%20Ministry%20Qualitative%20Panel%20Study%20Wave%201%20Report.pdf

Graveling, L. (2018b). *Living ministry: Mapping the wellbeing of Church of England Clergy and ordinands.* https://www.churchofengland.org/sites/default/files/2017-10/Living_Ministry_Panel_Survey_Wave_1_Report.pdf

Graveling, L. (2020). *How clergy thrive: Insights from living ministry*. Church House Publishing. https://www.churchofengland.org/sites/default/files/2020-10/How%20Clergy%20Thrive%20Downloadable%20for%20Local%20Non%20Commercial%20Use.pdf

Greenwell, K., Sereda, M., Coulson, N. S., Geraghty, A. W., Bradbury, K., & Hoare, D. J. (2021). 'That's just how I am': A qualitative interview study to identify factors influencing engagement with a digital intervention for tinnitus self-management. *British Journal of Health Psychology, 26*(3), 727-747. https://doi.org/10.1111/bjhp.12486

Guthrie, T., & Stickley, T. (2008). Spiritual experience and mental distress: A clergy perspective. *Mental Health, Religion and Culture, 11*(4), 387-402. https://doi.org/10.1080/13674670701484303

Hamer, M., Stamatakis, E., & Steptoe, A. (2009). Dose-response relationship between physical activity and mental health: The Scottish Health Survey. *British Journal of Sports Medicine, 43*(14), 1111-1114. https://doi.org/doi:10.1136/bjsm.2008.046243

Harmon, B. E., Blake, C. E., Armstead, C. A., & Hébert, J. R. (2013). Intersection of identities. Food, role, and the African–American pastor. *Appetite*, *67*, 44-52. https://doi.org/10.1016/j.appet.2013.03.007

Harmon, B. E., Strayhorn, S., Webb, B. L., & Hébert, J. R. (2018). Leading God's people: perceptions of influence among African–American Pastors. *Journal of Religion and Health, 57*(4), 1509-1523. https://doi.org/10.1007/s10943-018-0563-9

Harmon, B. E., Strayhorn, S. M., West, N. T., Schmidt, M., Webb, B. L., Grant, L., & Smith, S. (2021). Strategies for designing clergy and spouse obesity-related programs. *American Journal of Health Promotion, 35*(3), 399-408. https://doi.org/10.1177/0890117120960574

Harmon, B. E., West, N. T., Webb, B. L., Johnson, B. M., & Smith, S. (2023). Fit with faith: An exploratory study examining a behavior change intervention for african-american clergy and their spouses. *Journal of Religion and Health, 62*(4), 2627-2637. https://doi.org/10.1007/s10943-023-01820-9

Harvard Health Publishing. (2022, October 14). *Diseases & conditions: Fatigue and autoimmune disease.* https://www.health.harvard.edu/diseases-and-conditions/fatigue-and-autoimmune-disease

Hays, D. G., & McKibben, W. B. (2021). Promoting rigorous research: Generalizability and qualitative research. *Journal of Counseling & Development, 99*(2), 178-188. https://doi.org/10.1002/jcad.12365

Haward, J. (2016, April 19). *Sexuality and identity*. Baptist Times. https://www.baptist.org.uk/Articles/465692/Human_sexuality_and.aspx

Health & Care Professions Council. (2021, September 27). *What is supervision?* https://www.hcpc-uk.org/standards/meeting-our-standards/supervision-leadership-and-culture/supervision/what-is-supervision/

Heaton Baptist Church. (2017). *Senior minister person specification* [Job description]. Retrieved November 28, 2019, from https://freshstreams.net/jobs/senior-minister/

Henare, D., Hocking, C., & Smythe, L. (2003). Chronic pain: Gaining understanding through the use of art. *British Journal of Occupational Therapy, 66*(11), 511-518. https://doi.org/10.1177/030802260306601104

Hileman, L. (2008). The unique needs of Protestant clergy families: Implications for marriage and family counseling. *Journal of Spirituality in Mental Health, 10*(2), 119-144. https://doi.org/10.1080/19349630802081152

Hill, E. W., Darling, C. A., & Raimondi, N. M. (2003). Understanding boundary-related stress in clergy families. *Marriage & Family Review, 35*(1-2), 147-166. https://doi.org/10.1300/J002v35n01_09

Hillerbrand, H. J. (2019). Martin Luther. In *Encyclopaedia Britannica*. https://www.britannica.com/biography/Martin-Luther

Holaday, M., Lackey, T., Boucher, M., & Glidewell, R. (2001). Secondary stress, burnout, and the clergy. *American Journal of Pastoral Counseling, 4*(1), 53-72. https://doi.org/10.1300/J062v04n01_05

Hollins, J. T. (2018). *Exploring conflicting expectations within the church and their impact on the role of the pastor: A grounded theory study* [Doctoral dissertation, Sullivan University]. Sullivan University ProQuest Dissertations Publishing. https://www.proquest.com/openview/92f9edf82b0a39bf266458594db36dbd/1?pq-origsite=gscholar&cbl=18750

Hooten, E. (2011). *Clergy well-Being in the United Methodist Church: Twelve findings from surveys across the connection.* [Data summary]. WesPath. https://www.wespath.org/assets/1/7/FINALFourDataSources9JUN2011.pdf

Horstmann, D. (2018). Enhancing employee self-care: The moderating effect of personal initiative on health-specific leadership. *European Journal of Health Psychology, 25*(3), 96-106. https://doi.org/10.1027/2512-8442/a000014

Houdmont, J., Randall, R., Cheyne, A., Davis, S., Evans, H., & Faichney, J. (2019). UK postal delivery workers' occupational sun safety: Using behavior change theories to identify intervention pathways. *International Journal of Environmental Research and Public Health, 16*(19), Article 3712. https://doi.org/10.3390/ijerph16193712

Howlett, N., Schulz, J., Trivedi, D., Troop, N., & Chater, A. (2021). Determinants of weekly sitting time: Construct validation of an initial COM-B model and comparison of its predictive validity with the theory of planned behaviour. *Psychology & Health, 36*(1), 96-114. https://doi.org/10.1080/08870446.2020.1763994

Hughes, S. (2010). *Every Day with Jesus: One year Bible.* CWR.

Hughes, C., Masterson-Jones, A., Mitrovic, D., Brass, C., Wong, J., & Russell, P. (2019). *Future of food report* [Organisational research]. Sainsbury's. https://www.about.sainsburys.co.uk/~/media/Files/S/Sainsburys/pdf-downloads/futureoffood-10c.pdf

Iacovides, A., Fountoulakis, K. N., Kaprinis, St., & Kaprinis, G. (2003). The relationship between job stress, burnout and clinical depression. *Journal of Affective Disorders, 75*(3), 209-221. https://doi.org/10.1016/S0165-0327(02)00101-5

INDDEX Project. (2018). *Diet Quality Index - International (DQI-I): Data4Diets: Building blocks for diet-related food security analysis*. Tufts University, Boston, MA. https://inddex.nutrition.tufts.edu/data4diets

International Labour Organization. (2009). *Workplace well-being*. https://www.ilo.org/media/27366/download

Iovino, J. (2017, January 3). Getting in shape: Wesley's health tips apply today… mostly. *United Methodist Church*. http://ee.umc.org/who-we-are/getting-in-shape-wesley-health-tips-apply-today-mostly

Jaeger, M. E., & Rosnow, R. L. (1988). Contextualism and its implications for psychological inquiry. *British Journal of Psychology, 79*(1), 63-75. https://doi.org/10.1111/j.2044-8295.1988.tb02273.x

Jenkins, G. (2018). *Clergy supportive spiritual practices* [Doctoral dissertation, Waterloo Lutheran Seminary]. Scholars Commons @ Laurier. https://scholars.wlu.ca/etd/2046/

Jensma, J. L. (2016). Outcome study findings of an intensive outpatient program for missionaries and clergy. *Journal of Psychology and Theology, 44*(4), 281-289. https://doi.org/10.1177/009164711604400403

Johnston, M. S., Ricciardelli, R., & Whitten, C. (2023). "That's not rehabilitation, that's enabling": Correctional officer perspectives on the prison needle exchange program [Online only]. *Criminal Justice and Behavior*. https://doi.org/10.1177/00938548231207065

Journal of Holistic Nursing. (2019). *Description.* https://uk.sagepub.com/en-gb/eur/journal/journal-holistic-nursing#description

Kanipe, R. (2016). *Clergy stress, complex trauma and Sabbath practice: A study on Sabbath practice as healing process for clergy serving in stressful appointments* [Doctoral dissertation, Asbury Theological Seminary]. Asbury

Theological Seminary ProQuest Dissertations Publishing. https://www.proquest.com/openview/85fa7346628648299e71f3b294328a6b/1?pq-origsite=gscholar&cbl=18750

Kaveny, M. C. (2005). The Order of Widows: What the early Church can teach us about older women and health care. *Christian Bioethics, 11*(1), 11-34. https://doi.org/10.1080/13803600590926369

Kay, W. K. (2000a). Job satisfaction of British Pentecostal ministers. *Asian Journal of Pentecostal Studies, 3*(1), 83-97. https://www.aptspress.org/wp-content/uploads/2018/06/00-1-wkay.pdf

Kay, W. K. (2000b). Role conflict and British Pentecostal ministers. *Journal of Psychology and Theology, 28*(2), 119-124. https://doi.org/10.1177/009164710002800204

Kearney, J. M., de Graaf, C., Damkjaer, S., & Engstrom, L. M. (1999). Stages of change towards physical activity in a nationally representative sample in the European Union. *Public Health Nutrition, 2*(1a), 115-124. https://doi.org/10.1017/s1368980099000166

Kemery, E. R. (2006). Clergy role stress and satisfaction: Role ambiguity isn't always bad. *Pastoral Psychology, 54*(6), 561-570. https://doi.org/10.1007/s11089-006-0024-3

Kemp, A. H., Arias, J. A., & Fisher, Z. (2017). Social ties, health and wellbeing: A literature review and model. In Ibáñez, A., Sedeño, L., & García, A. M. (Eds.), *Neuroscience and Social Science: The Missing Link* (pp. 397-427). Springer International Publishing.

Khalil, H., & Tricco, A. C. (2022). Differentiating between mapping reviews and scoping reviews in the evidence synthesis ecosystem. *Journal of Clinical Epidemiology, 149,* 175-182. https://doi.org/10.1016/j.jclinepi.2022.05.012

Khenti, A., Fréel, S., Trainor, R., Mohamoud, S., Diaz, P., Suh, E., Sireesha J., Bobbili, S. J., & Sapag, J. C. (2015). Developing a holistic policy and intervention framework for global mental health. *Health Policy and Planning, 31*(1), 37-45. https://doi.org/10.1093/heapol/czv016

Kilanowski, J. F. (2017). Breadth of the socio-ecological model. *Journal of Agromedicine, 22*(4), 295-297. https://doi.org/10.1080/1059924X.2017.1358971

King's College London. (n.d.). *The experiences of ministry project.* Retrieved October 3, 2022, from https://www.kcl.ac.uk/business/research/projects/experiences-ministry

Kinman, G., McFall, O., & Rodriguez, J. (2011). The cost of caring? Emotional labour, wellbeing and the clergy. *Pastoral Psychology, 60*(5), 671-680. https://doi.org/10.1007/s11089-011-0340-0

Kivimäki, M., Ferrie, J. E., Head, J., Shipley, M. J., Vahtera, J., & Marmot, M. G. (2004). Organisational justice and change in justice as predictors of employee health: The Whitehall II study. *Journal of Epidemiology & Community Health, 58*(11), 931-937. https://doi.org/10.1136/jech.2003.019026

Koenig, H. G. (2012). Religion, spirituality, and health: The research and clinical implications. *ISRN Psychiatry, 2012*, Article 278730. https://doi.org/doi:10.5402/2012/278730

Krejcir, R. J. (2016). *Statistics on pastors: 2016 update*. Schaeffer Institute of Leadership Development. http://www.churchleadership.org/apps/articles/default.asp?blogid=4545&view=post&articleid=Statistics-on-Pastors-2016-Update&link=1&fldKeywords=&fldAuthor=&fldTopic=0

Krieger, S. (1991). *Social science and the self: Personal essays on an art form*. Rutgers University Press.

Kroeger, C. (1988). The neglected history of women in the early church. *Christian History Magazine, 7*(17), 6-9. https://christianhistoryinstitute.org/magazine/article/women-in-the-early-church/

Lape, S. (2021, October 25). *A doorway to the sacred: Encountering God in the theatre*. Baptist News Global. https://baptistnews.com/article/a-doorway-to-the-sacred-encountering-god-in-the-theater/

Larson, T. (2020). *A case study on the key habits of long-tenured pastors in the Southern Baptist Convention* [Doctoral dissertation, Liberty Baptist Theological Seminary]. Scholars Crossing: The Institutional Repository of Liberty University. https://digitalcommons.liberty.edu/doctoral/2504/

Lauder, R. (2023, March 29). *Encountering God through the arts.* The Tablet. https://thetablet.org/encountering-god-through-the-arts/

Lawlor, K. B., & Hornyak, M. J. (2012). Smart goals: How the application of smart goals can contribute to achievement of student learning outcomes. *Developments in Business Simulation and Experiential Learning, 39*, 259-267. https://absel-ojs-ttu.tdl.org/absel/article/view/90/86

Lawrence, P. (2019). Chapter 39: The proper amount of food. *Monastery Of Christ in The Desert.* https://christdesert.org/prayer/rule-of-st-benedict/chapter-39-the-proper-amount-of-food/

Lee, C., & Iverson-Gilbert, J. (2003). Demand, support, and perception in family-related stress among Protestant clergy. *Family Relations, 52*(3), 249-257. https://doi.org/10.1111/j.1741-3729.2003.00249.x

Le Gallais, T. (2008). Wherever I go there I am: Reflections on reflexivity and the research stance. *Reflective Practice, 9*(2), 145-155. https://doi.org/10.1080/14623940802005475

Leach, C. H. (2018). *My spiritual calling: A journey of encouraging health and wholeness* [Doctoral dissertation, Drew University]. Drew University ProQuest Dissertations Publishing. https://www.proquest.com/docview/2033865732?pq-origsite=gscholar&fromopenview=true

Leavey, G. (2008). UK clergy and people in mental distress: Community and patterns of pastoral care. *Transcultural Psychiatry, 45*(1), 79-104. https://doi.org/10.1177/1363461507087999

Leavey, G., Dura-Vila, G., & King, M. (2012). Finding common ground: The boundaries and interconnections between faith-based organisations and mental health services. *Mental Health, Religion & Culture, 15*(4), 349-362. https://doi.org/10.1080/13674676.2011.575755

Leavey, G., Loewenthal, K., & King, M. (2007). Challenges to sanctuary: The clergy as a resource for mental health care in the community. *Social Science & Medicine, 65*(3), 548-559. https://doi.org/10.1016/j.socscimed.2007.03.050

Leavey, G., Loewenthal, K., & King, M. (2016). Locating the social origins of mental illness: The explanatory models of mental illness among clergy from different ethnic and faith backgrounds. *Journal of Religion and Health, 55*(5), 1607-1622. https://doi.org/10.1007/s10943-016-0191-1

Leavey, G., Loewenthal, K., & King, M. (2017). Pastoral care of mental illness and the accommodation of African Christian beliefs and practices by UK clergy.

Transcultural Psychiatry, 54(1), 86-106. https://doi.org/10.1177/1363461516689016

Lee, C., & Iverson-Gilbert, J. (2003). Demand, support, and perception in family-related stress among Protestant clergy. *Family Relations, 52*(3), 249-257. https://doi.org/10.1111/j.1741-3729.2003.00249.x

Lee, J. J., & Miller, S. E. (2013). A self-care framework for social workers: Building a strong foundation for practice. *Families in Society, 94*(2), 96-103. https://doi.org/10.1606/1044-3894.4289

Lemmons, R., & Zanskas, S. (2019). Residential counselors and self care: A retrospective qualitative study of archival interview data. *Health Services Research and Managerial Epidemiology, 6*, 1-9. https://doi.org/10.1177/2333392819867017

Lifeway Research. (2015). *Pastor protection research study: Survey of 1,500 American pastors* [Data summary]. http://lifewayresearch.com/wp-content/uploads/2015/08/Pastor-Protection-Quantitative-Report-Final.pdf

Lim, R. B. T., Wee, W. K., Ananthanarayanan, J. A., Soh, Y. H., Goh, L. M. L., Tham, D. K. T., & Wong, M. L. (2020). Correlates, facilitators and barriers of physical activity among primary care patients with prediabetes in Singapore: A mixed methods approach. *BMC Public Health, 20*, Article 1. https://doi.org/10.1186/s12889-019-7969-5

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Lindholm, G., Johnston, J., Dong, F., Moore, K., & Ablah, E. (2016). Clergy wellness: An assessment of perceived barriers to achieving healthier lifestyles. *Journal of Religion and Health, 55*(1), 97-109. https://doi.org/10.1007/s10943-014-9976-2

Liu, G. (2019, July 5). What does the Bible say about the self-care movement? *ERLC.* https://erlc.com/resource-library/articles/what-does-the-bible-say-about-the-self-care-movement

Locke, E. A., & Latham, G. P. (2002). Building a practically useful theory of goal setting and task motivation: A 35-year odyssey. *American Psychologist, 57*(9), 705-717. https://psycnet.apa.org/doi/10.1037/0003-066X.57.9.705

MacCarthy, S., Mendoza-Graf, A., Wagner, Z., L. Barreras, J., Kim, A., Giguere, R., Carballo-Dieguez, A., & Linnemayr, S. (2021). The acceptability and feasibility of a pilot study examining the impact of a mobile technology-

based intervention informed by behavioral economics to improve HIV knowledge and testing frequency among Latinx sexual minority men and transgender women. *BMC Public Health, 21,* Article 341. https://doi.org/10.1186/s12889-021-10335-5

Mackenzie, K., Such, E., Norman, P., & Goyder, E. (2019). Sitting less at work: A qualitative study of barriers and enablers in organisations of different size and sector. *BMC Public Health, 19,* Article 884. https://doi.org/10.1186/s12889-019-7148-8

Markham, T. (2011). Project based learning a bridge just far enough. *Teacher Librarian, 39*(2), 38-42. https://search.proquest.com/openview/c1fb978702898324f288f75dba836879/1?pq-origsite=gscholar&cbl=38018

Marlow, J. J. (2017). *Divine appointments? Anticipating and avoiding problems in curate training relationships* [Doctoral dissertation, Durham University]. St John's College Durham University. https://www.churchofengland.org/sites/default/files/2018-05/Jon%20Marlow%20-%20Divine%20Appointments.pdf

Maxwell, J. (1992). Understanding and validity in qualitative research. *Harvard Educational Review, 62*(3), 279-301. https://doi.org/10.17763/haer.62.3.8323320856251826

Mayo Clinic Staff. (2023, April 29). Strength training: Get stronger, leaner, healthier. https://www.mayoclinic.org/healthy-lifestyle/fitness/in-depth/strength-training/art-20046670?pg=2

Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. *BMJ, 320,* 50-52. https://doi.org/10.1136/bmj.320.7226.50

McFerran, L., & Graveling, L. (2022). *Clergy wellbeing in a time of Covid autonomy, accountability and support.* The Church of England. https://www.churchofengland.org/sites/default/files/2022-01/Living%20Ministry%20W3%20Panel%20Survey%20Report%20-%20Clergy%20in%20a%20Time%20of%20Covid_0.pdf

McKenna, R. (2015). Contextualism in epistemology. *Analysis, 75*(3), 489-503. https://doi.org/10.1093/analys/anv029

McMinn, M. R., Lish, R. A., Trice, P. D., Root, A. M., Gilbert, N., & Yap, A. (2005). Care for pastors: Learning from clergy and their spouses. *Pastoral Psychology*, *53*(6), 563-581. https://doi.org/10.1007/s11089-005-4821-y

Meek, K. R., McMinn, M. R., Brower, C. M., Burnett, T. D., Mcray, B. W., Ramey, M. L., Swanson, D. W., & Villa, D. D. (2003). Maintaining personal resiliency: Lessons learned from evangelical protestant clergy. *Journal of Psychology and Theology*, *31*(4), 339–347. https://doi.org/10.1177/009164710303100404

Meeks, S., & Sherrell, Z. (2021, August 9). *What is the difference between fruits and vegetables?* Medical News Today. https://www.medicalnewstoday.com/articles/fruits-vs-vegetables

Mental Health First Aid England. (2016). Adult MHFA manual [Course handbook]. https://online.flippingbook.com/view/315002/

Mental Health First Aid England. (2019). *Andrew Curran – Neurobiology of adolescent mental health* [Video]. MHFA England. https://mhfastorage.blob.core.windows.net/mhfastoragecontainer/43b29f26dcaae811814ae0071b668081/Session%203%20-%20Suicide%20-%20Andrew%20Curran%20Part%20two.mp4.m4v?sv=2015-07-08&sr=b&sig=fpqE1levuaJOYYMa7Dsu1rIVXaiSqI0H9MHGgc5JbsU%3D&se=2024-05-26T12%3A09%3A57Z&sp=r

Mental Health UK. (n.d.). *Sleep and mental health*. https://mentalhealth-uk.org/help-and-information/sleep/

Mental Health UK. (2024). *The burnout report* [Data summary]. https://euc7zxtct58.exactdn.com/wp-content/uploads/2024/01/19145241/Mental-Health-UK_The-Burnout-Report-2024.pdf

Midlands and Lancashire Commissioning Support Unit. (2016). *Your guide to using logic models.* https://www.midlandsandlancashirecsu.nhs.uk/images/Logic_Model_Guide_AGA_2262_ARTWORK_FINAL_07.09.16_1.pdf

Michie, S., Atkins, L., & West, R. (2014). *The behaviour change wheel: A guide to designing interventions.* Silverback Publishing.

Michie, S., Richardson, M., Johnston, M., Abraham, C., Francis, J., Hardeman, W., Eccles, M. P., Cane, J., & Wood, C. E. (2013). The behavior change

technique taxonomy (v1) of 93 hierarchically clustered techniques: Building an international consensus for the reporting of behavior change interventions. *Annals of Behavioral Medicine, 46*(1), 81-95. https://doi.org/10.1007/s12160-013-9486-6

Michie, S., Van Stralen, M. M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science, 6,* Article 42. https://doi.org/10.1186/1748-5908-6-42

Millar, G. (2016, December 23). *What we need is more love and less paperwork - renewal and reform.* Diocese of Sheffield. Retrieved October 3, 2022, from https://www.sheffield.anglican.org/blog/diocese-of-sheffield/what-we-need-is-more-love-and-less-paperwork-renewal-and-reform

Millar, G. (2017). *Mission partnership development worker project: Information for applicants: S8-MPDW-info-pack* [Application pack]. Diocese of Sheffield. Retrieved October 3, 2022, from https://www.sheffield.anglican.org/UserFiles/File/Vacancies/S8-MPDW-Info-Pack.pdf

Miller, T. (n.d.). *Celtic spirituality: A beginner's guide*. Northumbria Community. https://www.northumbriacommunity.org/articles/celtic-spirituality-a-beginners-guide/

Milstein, G., Hybels, C. F., & Proeschold-Bell, R. J. (2020). A prospective study of clergy spiritual well-being, depressive symptoms, and occupational distress. *Psychology of Religion and Spirituality, 12*(4), 409-416. https://doi.org/10.1037/rel0000252

Miner, M. H. (2007). Burnout in the first year of ministry: Personality and belief style as important predictors. *Mental Health, Religion & Culture, 10*(1), 17-29. https://doi.org/10.1080/13694670500378017

Miner, M., Bickerton, G., Dowson, M., & Sterland, S. (2015). Spirituality and work engagement among church leaders. *Mental Health, Religion & Culture, 18*(1), 57-71. https://doi.org/10.1080/13674676.2014.1003168

Mind. (2021). *Coronavirus: the consequences for mental health* [Data summary]. https://www.mind.org.uk/media/8962/the-consequences-of-coronavirus-for-mental-health-final-report.pdf

Mitchell, E. (2022, February 25). *What are the benefits of strength training for women?* Bupa. https://www.bupa.co.uk/newsroom/ourviews/strength-training-benefits

Monod, S., Brennan, M., Rochat, E., Martin, E., Rochat, S., & Büla, C. J. (2011). Instruments measuring spirituality in clinical research: A systematic review. *Journal of General Internal Medicine, 26*(11), 1345-1357. http://dx.doi.org/10.1007/s11606-011-1769-7

Moody, A. (2019). *Health survey for England 2018 longstanding conditions* [Data summary]. NHS Digital. https://files.digital.nhs.uk/AA/E265E0/HSE18-Longstanding-Conditions-rep.pdf

Moore, B. (2010). *Analyses of coping resources and recent resource changes as a means to investigate burnout among Nazarene clergy* [Doctoral dissertation, Walden University]. Walden University ProQuest Dissertations Publishing. https://www.proquest.com/openview/e846eca2f398aa64160415bb8735ad43/1?pq-origsite=gscholar&cbl=18750

Moore, D. D., Brooks, J. E., & King, E. N. (2017). The meaning of obesity in the church: A pastoral leader's perspective. *Pastoral Psychology, 66*(1), 45-64. https://doi.org/10.1007/s11089-016-0716-2

Moore, G. F., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., Moore, L., O'Cathain, A., Tinati, T., Wight, D., & Baird, J. (2015). Process evaluation of complex interventions: Medical Research Council guidance. *BMJ, 2015*(350), Article h1258. https://doi.org/10.1136/bmj.h1258

Moreira-Almeida, A., Sharma, A., van Rensburg, B. J., Verhagen, P. J., & Cook, C. C. (2016). WPA position statement on spirituality and religion in psychiatry. *World Psychiatry, 15*(1), 87-88. https://doi.org/10.1002/wps.20304

Morgan, G. A., Leech, N. L., Gloeckner, G. W., & Barrett, K. C. (2013). *IBM SPSS for introductory statistics: Use and interpretation*. Routledge.

Muehlschlegel, P. A., Parkinson, E. A., Chan, R. Y., Arden, M. A., & Armitage, C. J. (2021). Learning from previous lockdown measures and minimising harmful biopsychosocial consequences as they end: A systematic review. *Journal of Global Health, 11*, Article 05008. https://doi.org/10.7189%2Fjogh.11.05008

Mulvaney, S. A. (2009). Improving patient problem solving to reduce barriers to diabetes self-management. *Clinical Diabetes, 27*(3), 99-105. https://doi.org/10.2337/diaclin.27.3.99

Murgu, C. (2021). "A modern disease of adaptation…"?: Technostress and academic librarians working in digital scholarship at ARL institutions. *The Journal of Academic Librarianship, 47*(5), Article 102400. https://doi.org/10.1016/j.acalib.2021.102400

Muse, S. (2007). Clergy in crisis: When human power isn't enough. *Journal of Pastoral Care & Counseling, 61*(3), 183-195. https://doi.org/10.1177/154230500706100303

Muse, S., Love, M., & Christensen, K. (2016). Intensive outpatient therapy for clergy burnout: How much difference can a week make? *Journal of Religion and Health, 55*(1), 147-158. https://doi.org/10.1007/s10943-015-0013-x

Nabi, H., Kivimaki, M., De Vogli, R., Marmot, M. G., & Singh-Manoux, A. (2008). Positive and negative affect and risk of coronary heart disease: Whitehall II prospective cohort study. *BMJ, 337*(7660), 32–36. https://doi.org/10.1136%2Fbmj.a118

Nath, J. (2010). 'God is a vegetarian': The food, health and bio-spirituality of Hare Krishna, Buddhist and Seventh-Day Adventist devotees. *Health Sociology Review, 19*(3), 356-368. https://doi.org/10.5172/hesr.2010.19.3.356

New Revised Standard Version Bible: Anglicised. (2017). Cambridge University Press. (Original work published 1989)

Ng Fat, L., Scholes, S., Boniface, S., Mindell, J., & Stewart-Brown, S. (2017). Evaluating and establishing national norms for mental wellbeing using the short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS): Findings from the Health Survey for England. *Quality of Life Research, 26*(5), 1129-1144. https://doi.org/10.1007/s11136-016-1454-8

National Health Service. (n.d.-a). *NHS health and wellbeing framework: Improving personal health and wellbeing.* https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/nhs-health-and-wellbeing-framework/elements-of-health-and-wellbeing/improving-personal-health-and-wellbeing/

National Health Service. (n.d.-c). *Online library of quality, service improvement and redesign tools: Developing your aims statement* [Organisational guidelines].

https://aqua.nhs.uk/wp-content/uploads/2023/07/qsir-developing-your-aims-statement.pdf

National Health Service. (2018, November 20). *Mindfulness.* https://www.nhs.uk/conditions/stress-anxiety-depression/mindfulness/

National Health Service. (2019). *What is a holistic needs assessment?* (Reference Number: HEY-697/2018). https://www.hey.nhs.uk/patient-leaflet/holistic-needs-assessment/

National Health Service. (2021a). *Gallstones*. https://www.nhs.uk/conditions/gallstones/

National Health Service. (2021b). *Meat in your diet.* https://www.nhs.uk/live-well/eat-well/food-types/meat-nutrition/

National Health Service. (2021c). *Physical activity guidelines for adults aged 19 to 64.* https://www.nhs.uk/live-well/exercise/exercise-guidelines/physical-activity-guidelines-for-adults-aged-19-to-64/

National Health Service Digital. (n.d.). *Adults' average BMI* [Data summary]. http://healthsurvey.hscic.gov.uk/data-visualisation/data-visualisation/explore-the-trends/weight/adult/bmi.aspx

National Health Service Digital. (2018). *Fruit & vegetables* [Data summary]. http://healthsurvey.hscic.gov.uk/data-visualisation/data-visualisation/explore-the-trends/fruit-vegetables.aspx

National Health Service Digital. (2019a). *Health survey for England 2018 adults' health* [Data summary]. https://files.digital.nhs.uk/E4/DAA235/HSE18-Adult-Health-rep.pdf

National Health Service Digital. (2019b). *Health survey for England 2018 longstanding conditions* [Data summary]. https://files.digital.nhs.uk/AA/E265E0/HSE18-Longstanding-Conditions-rep.pdf

National Health Service Digital. (2019c). *Statistics on obesity, physical activity and diet, England, 2019* [Data summary]. https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-obesity-physical-activity-and-diet/statistics-on-obesity-physical-activity-and-diet-england-2019/part-3-adult-obesity

National Health Service Digital. (2022). *Health survey England additional analyses, ethnicity and health, 2011-2019 experimental statistics: Wellbeing* [Data

summary]. https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-england-additional-analyses/ethnicity-and-health-2011-2019-experimental-statistics/wellbeing-copy

National Health Service Hertfordshire Partnership University. (2017, January 19). *The Care Act: Wellbeing.* https://www.hpft.nhs.uk/information-and-resources/care-act-2014/the-care-act-wellbeing/

National Institute for Health and Care Excellence. (2018). *Depression in adults: Recognition and management.* (Clinical guideline [CG90]). https://www.nice.org.uk/guidance/cg90/chapter/1-Guidance

National Institute for Health and Care Excellence. (2019). *Lung cancer in adults. Quality statement 5: Holistic needs assessment.* (Quality standard [QS17]). https://www.nice.org.uk/guidance/qs17/chapter/Quality-statement-5-Holistic-needs-assessment

National Institute for Health and Care Excellence. (2022). *Obesity: Identification, assessment and management*. (Clinical guideline [CG189]). https://www.nice.org.uk/guidance/cg189/ifp/chapter/obesity-and-being-overweight

National Institute for Health and Care Research. (2019). *Additional guidance for applicants including a clinical trial, pilot study or feasibility as part of a personal award application.* https://www.nihr.ac.uk/documents/additional-guidance-for-applicants-including-a-clinical-trial-pilot-study-or-feasibility-as-part-of-a-personal-award-application/11702#feasibility-and-pilot-studies

National Institutes of health. (2018). *Health risks of overweight & obesity*. https://www.niddk.nih.gov/health-information/weight-management/adult-overweight-obesity/health-risks?dkrd=/health-information/weight-management/health-risks-overweight

New Life Baptist Church Northallerton. (n.d.). *Videos* [YouTube channel]. YouTube. Retrieved January 11, 2024, from https://www.youtube.com/@newlifebaptistchurchnortha9327/search?query=jamie%20green

Norcross, J. C., Krebs, P. M., & Prochaska, J. O. (2011). Stages of change. *Journal of Clinical Psychology, 67*(2), 143–154. https://doi.org/10.1002/jclp.20758

Northumbrian Community. (2020). *Staying at nether springs.* https://www.northumbriacommunity.org/nether-springs/staying-at-nether-springs/

Nwosu, A. D., Ossai, E. N., Mba, U. C., Anikwe, I., Ewah, R., Obande, B. O., & Achor, J. U. (2020). Physician burnout in Nigeria: A multicentre, cross-sectional study. *BMC Health Services Research, 20,* Article 863. https://doi.org/10.1186/s12913-020-05710-8

Oakham Baptist Church. (2019). *Youth worker* [Job description]. Retrieved November 28, 2019, from https://www.oakhambaptist.org.uk/Publisher/File.aspx?ID=236538

Office for Health Improvement Disparities. (2022). *COVID-19 mental health and wellbeing surveillance report: 2. Important findings* [Data summary]. https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report/2-important-findings-so-far#changes-in-population-mental-health-and-wellbeing

Office for National Statistics. (2019a). *Measuring national well-being in the UK: International comparisons, 2019* [Data set]. https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuringnationalwellbeing/internationalcomparisons2019#health

Office for National Statistics. (2019b). *2018: Sickness absence rates of workers in the UK labour market, including number of days lost and reasons for absence* [Data set]. https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2018#what-are-the-reasons-for-sickness-absence

Office for National Statistics. (2020). *Number of workers in second jobs, and by employment type by age groups, 2009, 2014, 2018 and 2019* [Data set]. https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/adhocs/11464numberofworkersinsecondjobsandbyemploymenttypebyagegroups200920142018and2019

Office for National Statistics. (2023). *Average actual weekly hours of work for full-time workers (seasonally adjusted)* [Data set]. https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/timeseries/ybuy/lms

Ohrnberger, J., Fichera, E., & Sutton, M. (2017). The relationship between physical and mental health: A mediation analysis. *Social Science & Medicine*, *195*, 42-49. https://doi.org/10.1016/j.socscimed.2017.11.008

101 Planners (n.d.). *Smart Goals Template*. https://www.101planners.com/smart-goals-template/

Online Surveys. (n.d.). *About online surveys.* https://www.onlinesurveys.ac.uk/about/

Oppenheim, A. N. (1992). *Questionnaire design, interviewing and attitude measurement.* Continuum.

OSCAR. (2024). *Bi-vocational pastor/leader: The Harbour Church, Whitstable* [Job description]. Retrieved January 28, 2024, from https://oscar.org.uk/opportunities/bivocational-pastorleader

Ostir, G. V., Markides, K. S., Peek, M. K., & Goodwin, J. S. (2001). The association between emotional well-being and the incidence of stroke in older adults. *Psychosomatic Medicine, 63*(2), 210-215. https://journals.lww.com/psychosomaticmedicine/Abstract/2001/03000/The_Association_Between_Emotional_Well_Being_and.3.aspx

Pacheco, D., & Singh, A. (2023, May 23). *Why do we need sleep?* The Sleep Foundation. https://www.sleepfoundation.org/how-sleep-works/why-do-we-need-sleep

Padlet. (2021). *Padlet: It's a beautiful day. Make something beautiful*. https://padlet.com/

Pargament, K., Koenig, H., & Perez, L. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology*, *56*(4), 519-543. https://doi.org/10.1002/(SICI)1097-4679(200004)56:4<519::AID-JCLP6>3.0.CO;2-1

Park, S. (2021). *An evaluation of the effect of the soul care principles in the "slow to anger" program on levels of anger in Asian American church leaders in New York and New Jersey* [Doctoral dissertation, Nyack College, Alliance Theological Seminary]. Nyack College, Alliance Theological Seminary ProQuest Dissertations Publishing. https://www.proquest.com/openview/b0b70d7d71e5d2a49c2c0f1aed73206f/1?pq-origsite=gscholar&cbl=18750&diss=y

Partinen, M., & Gislason, T. (1995). Basic Nordic Sleep Questionnaire (BNSQ): A quantitated measure of subjective sleep complaints. *Journal of Sleep Research, 4*(1), 150-155. https://doi.org/10.1111/j.1365-2869.1995.tb00205.x

Pazos, P., Micari, M., & Light, G. (2010). Developing an instrument to characterise peer-led groups in collaborative learning environments: Assessing problem-solving approach and group interaction. *Assessment & Evaluation in Higher Education, 35*(2), 191-208. https://doi.org/10.1080/02602930802691572

Pepper, M., Sterland, S., & Powell, R. (2015). Methodological overview of the study of well-being through the Australian national church life survey. *Mental Health, Religion & Culture, 18*(1), 8-19. https://doi.org/10.1080/13674676.2015.1009717

Petersen, J. (2022, March 1). *How to hear God's voice: An interview with Pete Greig.* Bible Gateway Blog. https://www.biblegateway.com/blog/2022/03/how-to-hear-gods-voice-an-interview-with-pete-greig/

Peterson, U., Demerouti, E., Bergström, G., Samuelsson, M., Åsberg, M., & Nygren, Å. (2008). Burnout and physical and mental health among Swedish healthcare workers. *Journal of Advanced Nursing, 62*(1), 84-95. https://doi.org/10.1111/j.1365-2648.2007.04580.x

Petticrew, M., & Roberts, H. (2006). *Systematic reviews in the social sciences: A practical guide*. Blackwell Publishing.

Philips. (2019). *Global sleep survey: The global pursuit of better sleep health*. https://www.usa.philips.com/c-dam/b2c/master/experience/smartsleep/world-sleep-day/2019/2019-philips-world-sleep-day-survey-results.download.pdf

Pluye, P., & Hong, Q. N. (2014). Combining the power of stories and the power of numbers: Mixed methods research and mixed studies reviews. *Annual Review of Public Health, 35,* 29-45. https://doi.org/10.1146/annurev-publhealth-032013-182440

Prochaska, J. O., & DiClemente, C. C. (2005). The transtheoretical approach. In J. C. Norcross, & M. R. Goldfried (Ed..), *Handbook of Psychotherapy Integration* (pp. 147-171). Oxford University Press.

Proeschold-Bell, R. J., & Byassee, J. (2018). *Faithful and fractured: Responding to the clergy health crisis.* Baker Academic.

Proeschold-Bell, R. J., Eagle, D. E., Tice, L. C., Yao, J., Rash, J. A., Choi, J. Y., Stringfield, B., & Labrecque, S. M. (2023). The Selah pilot study of spiritual, mindfulness, and stress inoculation practices on stress-related outcomes among United Methodist clergy in the United States. *Journal of Religion and Health, 62*(4), 2686-2710. https://doi.org/10.1007/s10943-023-01848-x

Proeschold-Bell, R. J., & LeGrand, S. (2010). High rates of obesity and chronic disease amongst United Methodist clergy. *Obesity, 18*(9), 1867-1870. https://doi.org/doi:10.1038/oby.2010.102

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. https://doi.org/doi:10.1007/s10943-009-9250-1

Proeschold-Bell, R. J., & McDevitt, P. J. (2012). An overview of the history and current status of clergy health. *Journal of Prevention & Intervention in the Community, 40*(3), 177-179. https://doi.org/10.1080/10852352.2012.680407

Proeschold-Bell, R. J., Miles, A., Toth, M., Adams, C., Smith, B. W., & Toole, D. (2013b). Using effort-reward imbalance theory to understand high rates of depression and anxiety among clergy. *Journal of Primary Prevention, 34*(6), 439-453. https://doi.org/10.1007/s10935-013-0321-4

Proeschold-Bell, R. J., Swift, R., Moore, H. E., Bennett, G., Li, X., Blouin, R., Williams, V. P., Williams, R. B., & Toole, D. (2013a). 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. https://doi.org/10.1016/j.cct.2013.05.005

Proeschold-Bell, R. J., Turner, E. L., Bennett, G. G., Yao, J., Li, X. F., Eagle, D. E., Meyer, R. A., Williams, R. B., Swift, R. Y., Moore, E., Kolkin, M. A., Weisner, C. C., Rugani, K. M., Hough, H. J., Williams, V. P., & 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. https://doi.org/10.1016/j.amepre.2017.04.009

Proeschold-Bell, R. J., Yang, C., Toth, M., Corbitt Rivers, M., & Carder, K. (2014). Closeness to God among those doing God's work: A spiritual well-being measure for clergy. *Journal of Religion and Health, 53*(3), 878-894. https://doi.org/10.1007/s10943-013-9682-5

Proulx, W. A. (2008). *Depressive symptoms among members of the clergy serving on the New Mexico district of The Church of the Nazarene in The United States* [Doctoral dissertation, Capella University]. Capella University ProQuest Dissertations Publishing. https://www.proquest.com/openview/1c998b9514e34bf25931d32e8fb2edc4/1?pq-origsite=gscholar&cbl=18750

ProQol. (2012). *Professional quality of life measure* [Measurement tool]. https://www.proqol.org/ProQol_Test.html

Public Health England. (2016a). *Eatwell guide* [Government guidelines]. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/528193/Eatwell_guide_colour.pdf

Public Health England. (2016b). *Government dietary recommendations: Government recommendations for energy and nutrients for males and females aged 1 – 18 years and 19+ years* (PHE publications gateway number: 2016202) [Government guidelines]. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/618167/government_dietary_recommendations.pdf

Public Health England. (2019). *Achieving behaviour change: A guide for local government and partners* [Government guidelines]. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/875385/PHEBI_Achieving_Behaviour_Change_Local_Government.pdf

Public Health England. (2020, January 23). *Guidance: Health matters: Physical activity - prevention and management of long-term conditions.* https://www.gov.uk/government/publications/health-matters-physical-activity/health-matters-physical-activity-prevention-and-management-of-long-term-conditions

Querstret, D., & Cropley, M. (2012). Exploring the relationship between work-related rumination, sleep quality, and work-related fatigue. *Journal of Occupational Health Psychology, 17*(3), 341-353. https://doi:10.1037/a0028552

Querstret, D., Cropley, M., Kruger, P., & Heron, R. (2016). Assessing the effect of a Cognitive Behaviour Therapy (CBT)-based workshop on work-related rumination, fatigue, and sleep. *European Journal of Work and*

Organizational Psychology, 25(1), 50-67. https://doi.org/10.1080/1359432X.2015.1015516

Raihan, N., & Cogburn, M. (2023, March 6). *Stages of change theory* [Online guide]. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK556005/

Randall, K. J. (2013). Clergy burnout: Two different measures. *Pastoral Psychology, 62*(3), 333-341. https://doi.org/10.1007/s11089-012-0506-4

Research Excellence Framework. (2014a). *Research excellence framework: Background*. https://2014.ref.ac.uk/about/background/index.html

Research Excellence Framework. (2014b). *Research excellence framework: Key facts* [Fact sheet]. https://2014.ref.ac.uk/media/ref/content/pub/REF%20Brief%20Guide%202014.pdf

Religion Media Centre. (2018, March 27). *Factsheet: Christianity in Britain* [Fact sheet]. https://religionmediacentre.org.uk/factsheets/christianity-in-britain-factsheet/

Robbins, M., Francis, L., & Powell, R. (2012). Work-related psychological health among clergywomen in Australia. *Mental Health, Religion & Culture, 15*(9), 933-944. https://doi.org/10.1080/13674676.2012.698044

Robbins, M., & Hancock, N. (2015). Subjective well-being and psychological type among Australian clergy. *Mental Health, Religion & Culture, 18*(1), 47-56. https://doi.org/10.1080/13674676.2014.1003171

Roger Williams University. (2019). *Dimensions of wellness.* https://www.rwu.edu/undergraduate/student-life/health-and-counseling/health-education-program/dimensions-wellness

Rolph, J., Francis, L. J., Charlton, R., Robbins, M., & Rolph, P. (2011a). Women ministers of word and sacrament within the United Reformed Church: A health check. *Journal of Beliefs & Values, 32*(1), 19-32. https://doi.org/10.1080/13617672.2011.549307

Rolph, P., & Rolph, J. (2008). Perceptions of stress on those in rural ministry: Listening to church leaders. *Rural Theology, 6*(1), 55-63. https://doi.org/10.1179/rut_2008_6_1_005

Rolph, J., Rolph, P., Charlton, R., & Francis, L. (2011b). Getting out in the countryside walking: The health, lifestyle, and recreational pursuits of URC ministers. *Rural Theology, 9*(1), 49-59. http://dx.doi.org/10.1558/ruth.v9i1.49

Rolph, J., Siôn, T. A., Francis, L. J., & Rolph, P. (2014). Stress in rural ministry: Listening to Anglican clergy in England. *Rural Theology, 12*(2), 106-118. https://doi.org/10.1179/1470499414Z.00000000030

Rosik, C. H. (2011). Long-term outcomes of an intensive outpatient program for missionaries and clergy. *Journal of Psychology and Christianity, 30*(3), 175-183. https://www.proquest.com/docview/911809235?fromopenview=true&pq-origsite=gscholar

Rosik, C. H., Summerford, A., & Tafoya, J. (2009). Assessing the effectiveness of intensive outpatient care for Christian missionaries and clergy. *Mental Health, Religion and Culture, 12*(7), 687-700. https://doi.org/10.1080/13674670903127213

Rothmann, S., & Buys, C. (2011). Job demands and resources, psychological conditions, religious coping and work engagement of reformed church ministers. *Journal of Psychology in Africa, 21*(2), 173-183. https://doi.org/10.1080/14330237.2011.10820446

Rowatt, G. W. (2001). Stress and satisfaction in ministry families. *Review & Expositor, 98*(4), 523-543. https://doi.org/10.1177/003463730109800404

Rowell, J. L. (2010*). Clergy retention in the church of the Nazarene, the role of the District Superintendent in clergy decision-making regarding persistence in active vocational ministry* [Doctoral dissertation, Olivet Nazarene University]. Digital Commons @ Olivet. https://digitalcommons.olivet.edu/edd_diss/13/

Rubin, R. S. (2002). Will the real SMART goals please stand up. *The Industrial-Organizational Psychologist, 39*(4), 26-27. https://doi.org/10.1037/e576932011-003

Ruggiero, K. J., Resnick, H. S., Acierno, R., Coffey, S. F., Carpenter, M. J., Ruscio, A. M., Stephens, R. S., Kilpatrick, D. G., Stasiewicz, P. R., Roffman, R. A., Bucuvalas, M., & Galea, S. (2006). Internet-based intervention for mental health and substance use problems in disaster-affected populations: A pilot

feasibility study. *Behavior Therapy, 37*(2), 190-205. https://doi.org/10.1016/j.beth.2005.12.001

Samushonga, H. M. (2019). A theological reflection of bivocational pastoral ministry: A personal reflective account of a decade of bivocational ministry practice experience. *Practical Theology, 12*(1), 66-80. https://doi.org/10.1080/1756073X.2019.1575040

Scannell, N., Villani, A., Mantzioris, E., & Swanepoel, L. (2020). Understanding the self-perceived barriers and enablers toward adopting a Mediterranean diet in Australia: An application of the theory of planned behaviour framework. *International Journal of Environmental Research and Public Health, 17*(24), Article 9321. https://doi.org/10.3390/ijerph17249321

Schat, A. C., Kelloway, E. K., & Desmarais, S. (2005). The Physical Health Questionnaire (PHQ): Construct validation of a self-report scale of somatic symptoms. *Journal of Occupational Health Psychology, 10*(4), 363-381. https://doi.org/10.1037/1076-8998.10.4.363

Scott, G., & Lovell, R. (2015). The rural pastors initiative: Addressing isolation and burnout in rural ministry. *Pastoral Psychology, 64*(1), 71-97. https://doi.org/10.1007/s11089-013-0591-z

Seeley, M. (2018). Foreword. In L. Graveling. *Living Ministry: Negotiating wellbeing: Experiences of ordinands and clergy in the Church of England* (p. 3). https://www.churchofengland.org/sites/default/files/2018-10/Living%20Ministry%20Qualitative%20Panel%20Study%20Wave%201%20Report.pdf

Segal, M. (2016, March 14). *The insanity of 'self-care'.* Desiring God. https://www.desiringgod.org/articles/the-insanity-of-self-care

Shah, N. (2020). *Analysis of cut points on SWEMWBS based on PHQ-9 and GAD-7 cut points indicating depression and anxiety* [Data summary]. https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/howto/cut_points_on_swemwbs_analyses.docx

Shaw, M. (2013, November 21). *Interdependence is counter-cultural*. Baptists Together. https://www.baptist.org.uk/Articles/378895/Interdependence_is_Counter.aspx

Shaw, M., Lukman, R., Simmons, L. W., & Reynolds, R. (2021). Clergy wholeness study: How occupational distress, depression, and social support inform the health of clergy. *Journal of Pastoral Care & Counseling, 75*(1), 23-32. https://doi.org/10.1177/1542305020968046

Sheldon, K. M. (2006). Catholic guilt? Comparing Catholics' and Protestants' religious motivations. *The International Journal for the Psychology of Religion, 16*(3), 209-223. https://doi.org/10.1207/s15327582ijpr1603_5

Sielaff, A. M., Davis, K. R., & McNeil, J. D. (2021). Literature review of clergy resilience and recommendations for future research. *Journal of Psychology and Theology, 49*(4), 308-323. https://doi.org/10.1177/0091647120968136

Signalness, J. (2016, January 29). *How does a Catholic priest differ from ministers in other religious faiths?* Diocese of Bismarck. https://bismarckdiocese.com/news/how-does-a-catholic-priest-differ-from-ministers-in-other-religious-faiths

Sliter, M., & Jones, M. (2016). A qualitative and quantitative examination of the antecedents of customer incivility. *Journal of Occupational Health Psychology, 21*(2), 208–219. http://dx.doi.org/10.1037/a0039897

Smith, A. (2022). Celtic spirituality: Qualitative analysis of an experience of compassion, connection, creation, contemplation and congruence. *Mental Health, Religion & Culture, 25*(1), 19-32. https://doi.org/10.1080/13674676.2021.2009788

Smith, B. (2018). Generalizability in qualitative research: Misunderstandings, opportunities and recommendations for the sport and exercise sciences. *Qualitative Research in Sport, Exercise and Health, 10*(1), 137-149. https://doi.org/10.1080/2159676X.2017.1393221

Smith, B., & McGannon, K. R. (2018). Developing rigor in qualitative research: Problems and opportunities within sport and exercise psychology. *International Review of Sport and Exercise Psychology, 11*(1), 101-121. https://doi.org/10.1080/1750984X.2017.1317357

Smith, J. W. (2016). *Thriving in ministry: Investigating the impact of participation in wholistic clergy wellness incubator groups on clergy self-evaluation of wellness* [Doctoral dissertation, Drew University]. Drew University ProQuest Dissertations Publishing.

https://www.proquest.com/openview/73d8f2558c15e44e381fff7d97670aaa/1?pq-origsite=gscholar&cbl=18750

Smith, M. (2020, January 17). *Three quarters of Brits get less than eight hours sleep*. YouGov. https://yougov.co.uk/topics/health/articles-reports/2020/01/17/three-quarters-brits-get-less-eight-hours-sleep

Song, M., Fung, T. T., Hu, F. B., Willett, W. C., Longo, V. D., Chan, A. T., & Giovannucci, E. L. (2016). Association of animal and plant protein intake with all-cause and cause-specific mortality. *JAMA Internal Medicine, 176*(10), 1453-1463. https://doi.org/10.1001/jamainternmed.2016.4182

Soto, L. A. (2015). *Team approach to ministry: Effective strategy against pastoral burnout* [Doctoral dissertation, Asbury Theological Seminary]. Asbury Theological Seminary ProQuest Dissertations Publishing. https://www.proquest.com/openview/7a2969504f1b18f2c51797ff3043cee0/1?pq-origsite=gscholar&cbl=18750

Sport England. (2020). *Active lives adult survey November 2018/19 Report* [Data summary]. https://sportengland-production-files.s3.eu-west-2.amazonaws.com/s3fs-public/2020-04/Active%20Lives%20Adult%20November%2018-19%20Report..pdf?VersionId=BhkAy2K28pd9bDEz_NuisHl2ppuqJtpZ

Sport England. (2024). *Summary: The rising cost of living and its impact on sport and physical activity* [Data summary]. https://sportengland-production-files.s3.eu-west-2.amazonaws.com/s3fs-public/2024-01/Cost%20of%20living%20impact%20report%20-%20summary%20%28January%202024%29..pdf?VersionId=ClxvrzbuQLNDfoxuIVIuK_RcVmC2yXc6

Sprajcer, M., Dawson, D., Kosmadopoulos, A., Sach, E. J., Crowther, M. E., Sargent, C., & Roach, G. D. (2023). How tired is too tired to drive? A systematic review assessing the use of prior sleep duration to detect driving impairment. *Nature and Science of Sleep, 15*(2023), 175-206. https://doi.org/10.2147/NSS.S392441

Stainton Rogers, W., & Stainton Rogers, R. (1997). Does critical psychology mean the end of the world? In T. Ibanez & L. Iniguez (Eds.), *Critical Social Psychology* (pp. 67-82). Sage.

Staley, R. C., McMinn, M. R., Gathercoal, K., & Free, K. (2013). Strategies employed by clergy to prevent and cope with interpersonal isolation. *Pastoral Psychology, 62*(6), 843-857. https://doi.org/10.1007/s11089-012-0473-9

Stewart-Brown, S., Tennant, A., Tennant, R., Platt, S., Parkinson, J., & Weich, S. (2009). Internal construct validity of the Warwick-Edinburgh mental well-being scale (WEMWBS): A Rasch analysis using data from the Scottish health education population survey. *Health and Quality of Life Outcomes, 7*, Article 15. https://doi.org/10.1186/1477-7525-7-15

Sturges, J., Clinton, M., Conway, N., & Budjanovcanin, A. (2019). I know where I'm going: Sensemaking and the emergence of calling. *Journal of Vocational Behavior, 114*, 57-68. https://doi.org/10.1016/j.jvb.2019.02.006

Summer, J. (2022, April 15). *Eight health benefits of sleep.* The Sleep Foundation. https://www.sleepfoundation.org/how-sleep-works/benefits-of-sleep

Sussman, S. Y., Ayala, N., Pokhrel, P., & Herzog, T. A. (2022). Reflections on the continued popularity of the transtheoretical model. *Health Behavior Research, 5*(3), Article 2. https://doi.org/10.4148/2572-1836.1128

Swann, C., Jackman, P. C., Lawrence, A., Hawkins, R. M., Goddard, S. G., Williamson, O., Schweickle, M. J., Vella, S. A., Rosenbaum, S., & Ekkekakis, P. (2023). The (over) use of SMART goals for physical activity promotion: A narrative review and critique. *Health Psychology Review, 17*(2), 211-226. https://doi.org/10.1080/17437199.2021.2023608

Syrek, C. J., Weigelt, O., Peifer, C., & Antoni, C. H. (2017). Zeigarnik's sleepless nights: How unfinished tasks at the end of the week impair employee sleep on the weekend through rumination. *Journal of Occupational Health Psychology, 22*(2), 225-238. https://psycnet.apa.org/doi/10.1037/ocp0000031

Taylor & Francis Group. (n.d.). *Research impact: A guide to creating, capturing, and evaluating the impact of your research*. Author Services. https://authorservices.taylorandfrancis.com/wp-content/uploads/2021/03/Research_impact_ebook.pdf

Tedx Talks. (2016, July 5). *Finding our enlightened state | Andrew Newberg | TEDxPenn* [Video]. YouTube. https://www.youtube.com/watch?v=7SJCDLHyeqk

Terry, J. D., & Cunningham, C. J. (2020). The sacred and stressed: Testing a model of clergy health. *Journal of Religion and Health, 59*, 1541-1566. https://doi.org/10.1007/s10943-019-00920-9

Terry, J. D., & Cunningham, C. J. (2021). Some rest for the weary? A qualitative analysis of clergy methods for managing demands. *Journal of Religion and Health, 60*, 1230-1247. https://doi.org/10.1007/s10943-020-01086-5

Thabane, L., Cambon, L., Potvin, L., Pommier, J., Kivits, J., Minary, L., Nour, K., Blaise, P., Charlesworth, J., & Alla, F. (2019). Population health intervention research: What is the place for pilot studies? *Trials, 20*, Article 309. https://doi.org/10.1186/s13063-019-3422-4

Thabane, L., Ma, J., Chu, R., Cheng, J., Ismaila, A., Rios, L. P., Robson, R., Thabane, M., Giangregorio, L., & Goldsmith, C. H. (2010). A tutorial on pilot studies: The what, why and how. *BMC Medical Research Methodology, 10*(1), Article 1. https://doi.org/10.1186/1471-2288-10-1

The Baptist Union of Great Britain. (1999). *Covenant 21: Covenant for a gospel people* [Organisational guidelines]. https://www.baptist.org.uk/Publisher/File.aspx?ID=163927&view=browser

The Chartered Institute of Personnel and Development. (2019, April 9). *Well-being at work* [Fact sheet]. https://www.cipd.co.uk/knowledge/culture/well-being/factsheet

The Church of England. (n.d.-a). *Clergy payroll.* https://www.churchofengland.org/resources/clergy-resources/national-clergy-hr/clergy-payroll

The Church of England. (n.d.-b). *Living ministry: What helps clergy flourish in ministry?* https://www.churchofengland.org/resources/diocesan-resources/ministry/ministry-development/living-ministry

The Church of England. (n.d.-c). *Living ministry research: Project summary.* https://www.churchofengland.org/sites/default/files/2017-10/living_ministry_project_summary_0.pdf

The Church of England. (n.d.-d). *The national assembly of the Church of England: General synod*. https://www.churchofengland.org/about/general-synod

The Church of England. (2019a). *Statistics for mission 2019* [Data set]. https://www.churchofengland.org/sites/default/files/2020-10/2019StatisticsForMission.pdf

The Church of England. (2019b). *The Church of England covenant for the care and well-being of clergy: A document for reflection and action for the clergy* [Workbook]. https://www.churchofengland.org/sites/default/files/2020-07/COVENANT2_Clergy5.pdf

The Church of England. (2020). *Covenant for clergy care and wellbeing.* https://www.churchofengland.org/resources/clergy-resources/national-clergy-hr/supporting-clergy-health-and-wellbeing/covenant#na

The Diocese of Sheffield. (n.d.). *Mission partnerships development worker project.* Retrieved October 3, 2022, from https://www.sheffield.anglican.org/development-worker-project

The Diocese of Sheffield. (2014, August 12). *£1 million cash injection announced to boost Christian mission in the region.* Retrieved October 3, 2022, from https://www.sheffield.anglican.org/news/archive/-1-million-cash-injection-announced-to-boost-christian-mission-in-the-region

The Diocese of Sheffield. (2014). *Mission partnership development project* [Fact Sheet]. Retrieved October 3, 2022, from https://www.sheffield.anglican.org/UserFiles/File/Parish_Support/Mission_Partnerships/Information_for_Mission_Partnerships.pdf

The Holy Rule of St. Benedict. (1949). The Order of Saint Benedict: The Rule of Benedict. https://archive.osb.org/rb/text/rbemjo1.html#36 (Original work published 516)

The Institution of Occupational Safety and Health. (2015). *Working well. Guidance on promoting health and wellbeing at work* (POL4339/030517/5Y). https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=3cb309511cca8f2f3facee0488e6a6d3bd7e29d4

The Sleep Charity. (2021). *Sleep deprivation*. https://thesleepcharity.org.uk/information-support/adults/sleep-deprivation/

The University of Nottingham. (n.d.-a). *Automated transcription costs, charging and usage policy.* https://uniofnottm.sharepoint.com/sites/DigitalResearch/SitePages/Costs,-charging-and-usage-policy.aspx

The University of Nottingham. (n.d.-b). *Getting to grips with academic writing (online).* https://training.nottingham.ac.uk/Course?courseref=GTGWAWW&dates=0

The University of Nottingham. (n.d.-c). *What is NUsearch?* https://www.nottingham.ac.uk/library/collections/nusearch/nusearchfaqs.aspx

The Vegan Society. (n.d.). *Worldwide growth of veganism.* https://www.vegansociety.com/news/media/statistics/worldwide

The Working Time Regulations (1998). https://www.legislation.gov.uk/uksi/1998/1833/regulation/4/made

Tickle-Degnen, L. (2013). Nuts and bolts of conducting feasibility studies. *The American Journal of Occupational Therapy, 67*(2), 171-176. https://doi.org/10.5014%2Fajot.2013.006270

Timmins, F., & Caldeira, S. (2017). Assessing the spiritual needs of patients. *Nursing Standard, 31*(29), 47-53. https://doi.org/10.7748/ns.2017.e10312

Tomic, W., Tomic, D. M., & Evers, W. J. (2004). A question of burnout among Reformed Church ministers in The Netherlands. *Mental Health, Religion & Culture, 7*(3), 225-247. https://doi.org/10.1080/13674670310001602472

Tomova, A., Bukovsky, I., Rembert, E., Yonas, W., Alwarith, J., Barnard, N. D., & Kahleova, H. (2019). The effects of vegetarian and vegan diets on gut microbiota. *Frontiers in Nutrition, 6*, Article 47. https://doi.org/10.3389/fnut.2019.00047

Trades Union Congress. (2019, March 1). *Workers in the UK put in more than £32 billion worth of unpaid overtime last year - TUC analysis.* https://www.tuc.org.uk/news/workers-uk-put-more-ps32-billion-worth-unpaid-overtime-last-year-tuc-analysis

Trades Union Congress. (2023, June 5). *Austerity and the pandemic: How cuts damaged four vital pillars of pandemic resilience*. https://www.tuc.org.uk/research-analysis/reports/austerity-and-pandemic

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry, 16*(10), 837-851. https://doi.org/10.1177/1077800410383121

Trihub, B. L., McMinn, M. R., Buhrow Jr, W. C., & Johnson, T. F. (2010). Denominational support for clergy mental health. *Journal of Psychology and Theology, 38*(2), 101-110. https://doi.org/10.1177/009164711003800203

Turton, D. W., & Francis, L. J. (2007). The relationship between attitude toward prayer and professional burnout among Anglican parochial clergy in

England: Are praying clergy healthier clergy? *Mental Health, Religion & Culture, 10*(1), 61-74. https://doi.org/10.1080/13674670601012246

University College London. (2012). *Whitehall II - stress and health study: Phase 11: 2012-13* [Measurement tool]. https://www.ucl.ac.uk/psychiatry/sites/psychiatry/files/s11-questionnaire.pdf

Upenieks, L., & Eagle, D. E. (2024). Divine struggles among those doing God's work: A longitudinal assessment predicting depression and burnout and the role of social support in United Methodist clergy. *Sociology of Religion, 85*(1), 83-111. https://doi.org/10.1093/socrel/srad014

US Religion Census. (2020). *Maps and data files for 2020: 2020 Group detail data by nation, state, county and metro.* https://www.usreligioncensus.org/node/1639

Vandevala, T., Pavey, L., Chelidoni, O., Chang, N. F., Creagh-Brown, B., & Cox, A. (2017). Psychological rumination and recovery from work in intensive care professionals: Associations with stress, burnout, depression and health. *Journal of Intensive Care, 5*, Article 16. https://doi.org/10.1186%2Fs40560-017-0209-0

VanLoon, P. (2009). The practice of interpersonal forgiveness in the personal and professional lives of clergy. *Journal of Pastoral Care & Counseling, 63*(3–4), 1–9. https://doi.org/10.1177/154230500906300307

Van Teijlingen, E. R., & Hundley, V. (2001). Social research update: The importance of pilot studies. *Sociology at Surrey, 35*, 2-4. https://sru.soc.surrey.ac.uk/SRU35.PDF

Vizard, T., & Joloza, T. (2021, May 5). *Are we facing a mental health pandemic?* Office for National Statistics. https://blog.ons.gov.uk/2021/05/05/are-we-facing-a-mental-health-pandemic/

Wallace, A. C., Proeschold-Bell, R. J., Legrand, S., James, J., Swift, R., Toole, D., & Toth, M. (2012). Health programming for clergy: An overview of protestant programs in the United States. *Pastoral Psychology, 61*(1), 113-143. https://doi.org/10.1007/s11089-011-0382-3

Wantland, D. J., Portillo, C. J., Holzemer, W. L., Slaughter, R., & McGhee, E. M. (2004). The effectiveness of web-based vs. non-web-based interventions: A meta-analysis of behavioral Change Outcomes. *Journal of Medical Internet Research, 6*(4), Article e40. https://doi.org/10.2196/jmir.6.4.e40

Warwick Medical School. (2021). *Collect, score, analyse and interpret WEMWBS: Analysis.* https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/howto/

Warwick University. (2024). *Social Sciences Centre for Education Studies: The Revd Canon Professor Leslie J. Francis*. https://warwick.ac.uk/fac/soc/cedar/staff/lfrancisprofile/

Watkins, E. R. (2008). Constructive and unconstructive repetitive thought. *Psychological Bulletin, 134*(2), 163-206. https://doi.org/10.1037/0033-2909.134.2.163

Watt, L., & Voas, D. (2015). Psychological types and self-assessed leadership skills of clergy in the Church of England. *Mental Health, Religion & Culture, 18*(7), 544-555. https://doi.org/10.1080/13674676.2014.961250

Weaver, A. J., Larson, D. B., Flannelly, K. J., Stapleton, C. L., & Koenig, H. G. (2002). Mental health issues among clergy and other religious professionals: A review of research. *Journal of Pastoral Care & Counseling, 56*(4), 393-403. https://doi.org/10.1177/154230500205600408

Weaver, L. M. (n.d.). *The priesthood of all believers.* Baptist World Alliance. https://baptistworld.org/mission-guide/the-priesthood-of-all-believers/

Webb, B. L., & Bopp, M. J. (2017). Results of walking in faith: A faith-based physical activity program for clergy. *Journal of Religion and Health, 56*(2), 561-574. https://doi.org/10.1007/s10943-016-0255-2

Webb, R. R. (n.d.). *Supporting clergy health – Health & wellness Initiative: The Duke Endowment*. Duke Endowment. Retrieved October 29, 2019, from https://wp.dukeendowment.org/story/supporting-clergy-health-0

Webber, D., Guo, Z., & Mann, S. (2013). Self-care in health: We can define it, but should we also measure it? *SelfCare 4*(5), 101-106. https://pdfs.semanticscholar.org/089a/127edde7f96f2ea43f01818b804eb8f6c563.pdf

Wells, C. R. (2013). The moderating effects of congregational and denominational support on the impact of stress on clerical emotional and physical health status. *Pastoral Psychology, 62*, 873-888. https://doi.org/10.1007/s11089-013-0522-z

WesPath Benefits / Investments. (2015). *Clergy health survey report* (4785/061015) [Data summary]. https://www.wespath.org/assets/1/7/4785.pdf

WesPath Benefits / Investments. (2017). *Well-being survey of the United Methodist church active U.S. clergy—2017* (5058/072717) [Data summary]. https://www.wespath.org/assets/1/7/5058.pdf

WesPath Benefits / Investments. (2019). *2019 Clergy well-being report summary A snapshot of clergy well-being in each of the 5 dimensions* (5390/061819) [Data summary]. https://www.wespath.org/Assets/1/7/5390.pdf

WesPath Benefits / Investments. (2021a). *2021 Clergy well-being survey highlights* [Data summary]. https://www.wespath.org/Assets/1/7/5754.pdf

WesPath Benefits / Investments. (2021b). *2021 Clergy well-being survey: Past decade shows decline in well-being for UM clergy*. https://www.wespath.org/health-well-being/health-well-being-resources/clergy-congregational-resources/clergy-well-being-research

WesPath Benefits / Investments. (2023). *2023 Clergy well-being survey highlights* (5991/111023) [Data summary]. https://www.wespath.org/assets/1/7/5991.pdf

What Works Wellbeing. (2014). *What is wellbeing*. https://whatworkswellbeing.org/about-wellbeing/what-is-wellbeing/

Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in qualitative research. *Qualitative Health Research, 11*(4), 522-537. https://doi.org/10.1177/104973201129119299

Wieland, M. L., Njeru, J. W., Hanza, M. M., Boehm, D. H., Singh, D., Yawn, B. P., Patten, C. A., Clark, M. M., Weis, J. A., Osman, A., Goodson, M., Porraz Capetillo, M. D., Hared, A., Hasley, R., Guzman-Corrales, L., Sandler, R., Hernandez, V., Novotny, P., Sloan, J. A., & Sia, I. G. (2017). Pilot feasibility study of a digital storytelling intervention for immigrant and refugee adults with diabetes. *The Diabetes Educator, 43*(4), 349-359. https://doi.org/10.1177/0145721717713317

Wilkinson, S. (1988). The role of reflexivity in feminist psychology. *Women's Studies International Forum, 11*(5), 493-502. https://doi.org/10.1016/0277-5395(88)90024-6

Wilson, J. J., Blackburn, N. E., O'Reilly, R., Kee, F., Caserotti, P., & Tully, M. A. (2019). Association of objective sedentary behaviour and self-rated health in English older adults. *BMC Research Notes, 12,* Article 12. https://doi.org/10.1186/s13104-019-4050-5

Woods, A., Jones, N., Bernini, M., Callard, F., Alderson-Day, B., Badcock, J. C., Bell, V., Cook, C. C., Csordas, T., Humpston, C., Krueger, J., Larøi, F., McCarthy-Jones, S., Moseley, P., Powell, H., Raballo, A., Smailes, D. & Charles Fernyhough, C. (2014). Interdisciplinary approaches to the phenomenology of auditory verbal hallucinations. *Schizophrenia Bulletin, 40*(4), 246–254. https://doi.org/10.1093/schbul/sbu003

World Health Organisation. (2019). *Self-care for health and well-being.* https://www.who.int/health-topics/self-care#tab=tab_1

Wortmann J. (2013). Religious coping. In M.D. Gellman, & J.R. Turner (Ed.), *Encyclopedia of Behavioral Medicine* (pp. 107). Springer. https://doi.org/10.1007/978-1-4419-1005-9

Wright, N. G. (2016). *Baptist churches: An introduction* [Organisational guidelines]. Baptists Together. https://www.baptist.org.uk/Publisher/File.aspx?ID=168472&view=browser

Wyatt, S., Gage, J., & Taylor, L. (2017). *Ely clergy wellbeing survey 2016 – FINAL REPORT (May 2017).* https://d3hgrlq6yacptf.cloudfront.net/5f0f7281dadce/content/pages/documents/15682071391566243608.pdf

Wyatt, S., Gage, J. & Taylor, L. (2019). *Ely clergy wellbeing survey 2019 – FINAL REPORT (March 2020).* https://d3hgrlq6yacptf.cloudfront.net/5f0f7281dadce/content/pages/documents/1585216693.pdf

Yao, J., Steinberg, D., Turner, E. L., Cai, G. Y., Cameron, J. R., Hybels, C. F., Eagle, D. E., Milstein, G., Rash, J. A., & Proeschold-Bell, R. J. (2023). When shepherds shed: Trajectories of weight-related behaviors in a holistic health intervention tailored for US Christian clergy [Published online]. *Journal of Religion and Health*. https://doi.org/10.1007/s10943-023-01910-8

Yew, E. H., & Goh, K. (2016). Problem-based learning: An overview of its process and impact on learning. *Health Professions Education, 2*(2), 75-79. http://dx.doi.org/10.1016/j.hpe.2016.01.004

Zavaleta, D., Samuel, K., & Mills, C. T. (2017). Measures of social isolation. *Social Indicators Research, 131*(1), 367-391. https://doi.org/10.1007/s11205-016-1252-2

Zondervan. (2024). *Company profile*. https://www.zondervan.com/about-us/company-profile/

Appendices

Appendix A - Literature Searching Strategy

Research question:					
Concept (These are the key words you've used to define your research question)	Clergy	Holistic health	Behaviours (US spelling Behavior)	Barriers & facilitators	
Synonyms (Alternative words that mean the same thing, you can use a thesaurus to find these)	Pastor, minister, reverend, preacher, clergyperson, vicar, rector	Physical, mental, spiritual, social, financial, occupational	Actions Conduct Performance Functioning Practices	Limit Obstacle Boundaries Impediment Inhibit Prevent Preclude prohibit	Promote, Booster, Benefit, Improve, Bolster, Support, Develop, Encourage, Endorse, Foster, Nurture
Broader terms (These come in useful when your search returns too few results)	Religious leader Ordained	Biopsychosocial Health Wellbeing Functioning Ill-health Self-care	Outcomes Discrepancies 'Comparative to general adult population' Health profiles Rates of xxx e.g., stress Levels of xxx e.g., burnout Prevalence of xxx e.g., cardiac disease		
Narrower terms (These come in useful when your search returns too many results)	Baptist Pastor	Psychological, Cardiac, Diabetes, Stress, Heart disease, Depression, Mental, ill-health, Illness, Disease, Death, suicide, burnout, anxiety	Time vs self-care, Rejection of self-care, Self-care movement, 'Theological basis for care of the body'	Demands, lack of control, work pressure, work sanctification positives and negatives	
Related terms (Any other words which might facilitate your search)		Health and disease by names e.g., hypertension Meditation	Leisure time physical activity	Mitigate negative health outcomes Morbidity and mortality	
Truncation, alternative spellings & variants (Symbols are used in databases to help retrieve variant spellings and alternative endings. In the examples here	Clerg*	Health* Depress* Meditat* Mental* Spirit*			

you can see how the asterisk symbol * is used to find all words that begin with organi, and the question mark ? is used to find both British and US spellings of the same word. N.B. These symbols can vary between databases so it is important to check via the help pages of the databases)		Wellbeing? Stress*		

Appendix B - Study One – Participant Information

University of Nottingham
UK | CHINA | MALAYSIA

School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

PARTICIPANT INFORMATION

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Nazarene and Baptist Church Leaders' Wellbeing

Student: Jamie Green, msxjg4@nottingham.ac.uk

Supervisor: Jonathan Houdmont, jonathan.houdmont@nottingham.ac.uk

Ethics Reference Number: 0393

I would like to invite you to take part in a research study about the holistic (physical, mental, and spiritual) wellbeing of Nazarene and Baptist church leaders. Before you decide whether to participate it is important to understand why the research is being done and what it involves.

What is the purpose of this study?
Little is known about the wellbeing of Christian church leaders. The purpose of this study is to produce a snapshot of UK Baptist and Nazarene leaders' wellbeing across the physical, psychological, and spiritual domains. Results will inform further research concerning the protection and promotion of church leaders' health. The research is being conducted by Jamie Green as part of a PhD in occupational health psychology.

Why have I been invited?
You have been invited to participate because your primary job is that of church leader in the Nazarene or Baptist Church. Leader is defined here to encompass a wide range of roles including those of pastor, minister, reverend, preacher, clergyperson, vicar, rector, among others. You may have been invited by the student researcher, your church, or found a link to this questionnaire via an advert in a publication.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to give your consent before completing an anonymous questionnaire. You may change your mind about being involved at any time or decline to answer a particular question. You are free to withdraw at any point before or during the study without giving a reason. Once you have submitted responses it is not possible to withdraw your data as your anonymous responses cannot be identified.

What will I be asked to do?
If you choose to take part, you will be asked to complete an anonymous online questionnaire consisting of questions about your physical, psychological, and spiritual wellbeing; this should take no longer than 20 minutes.

Will the research be of any personal benefit to me?
Whilst the study will not help you personally, the information derived from this study will contribute to the knowledge base on church leaders' wellbeing, and inform further research concerning the protection and promotion of church leaders' wellbeing.

University of Nottingham
UK | CHINA | MALAYSIA

Are there any possible disadvantages or risks in taking part?
This study discusses topics surrounding physical, psychological, and spiritual wellbeing that some may find sensitive. As such details are given at the end of the questionnaire regarding resources and organisations where help may be sought for a variety of general health and wellbeing concerns. As with any online activity the risk of a breach is always possible. We will do everything possible to ensure your answers in this study remain anonymous.

What will happen to the information I provide?
All responses are anonymous and will be kept confidential. Your responses will be stored in 'Online Surveys', a secure academic research survey platform; only the student researcher and her supervisor have access to data. As this research forms part of the student researcher's PhD, the collective anonymous answers may be viewed by examiners both at the University of Nottingham and externally.

The student researcher will use data from this project in her PhD thesis. She may also use the data in academic journal articles and presentations at academic conferences.

Should you wish to receive a summary of the results please contact the student researcher in the summer of 2020.

We will follow ethical and legal practice and all information will be handled in confidence.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the student researcher of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally – identifiable information possible. You can find out more about how we use your information and to read our privacy notice at: https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

At the end of the project all raw data will be kept securely by the University under the terms of its data protection policy after which it will be disposed of securely. The data will not be kept elsewhere. If you have any questions or concerns, please don't hesitate to ask. We can be contacted before and after your participation at the email addresses above.

What if there is a problem?
If you have any queries or complaints, please contact the student's supervisor in the first instance. If this does not resolve your query, please write to the Administrator to the Division of Psychiatry & Applied Psychology's Research Ethics Sub-Committee adrian.pantry1@nottingam.ac.uk who will pass your query to the Chair of the Ethics Committee.

Appendix C - Study One – Questionnaire

Clergy Health and Wellbeing Survey (Final)

Welcome

Thank you for participating!

Please answer all questions honestly: there are no right or wrong answers and your responses are anonymous.

Before we begin

To read the **Participant Information** click here.

What is the purpose of this study?

The purpose of this study is to gain a snapshot of the current state of clergy health and wellbeing in the UK.

Why have I been invited?

You have been invited because you work as a pastor, minister, reverend, preacher, clergyperson, vicar, rector (or other title) where church leadership is your primary job role.

What will I be asked to do?

If you choose to take part, you will be asked to complete an online questionnaire, this should take no longer than 20 minutes.

Do I have to take part?

It is up to you to decide whether or not to take part. You are free to withdraw at any point before or during the study without giving a reason.

Will the research be of any personal benefit to me?

We cannot promise the study will help you personally, but information gained from this study may inform future developments in the promotion of UK clergy health and wellbeing.

Are there any possible disadvantages or risks in taking part?

This study discusses topics surrounding health that some may find sensitive. Details are given at the end of the questionnaire regarding resources and organisations where help may be sought for general health and wellbeing concerns.

What will happen to the information I provide?

All responses are anonymous and cannot be linked back to you.

As this piece of research forms part of the student researcher's PhD, the collective anonymous answers will be assessed by supervisors and examiners both at the University of Nottingham and externally. Once all the participant responses have been collected, the student researcher will produce an academic journal article which may be published and read by the general public.

Please select each statement to show you agree with the following:

- ☐ I have read and understood the Participant Information
- ☐ I agree to take part in the questionnaire about clergy health and wellbeing
- ☐ I know how to contact the student researcher if I have questions about this study
- ☐ I understand that I am free to withdraw from the study without giving a reason
- ☐ I understand that for anonymous questionnaire studies, once I have completed the study and submitted my answers, the data cannot be withdrawn
- ☐ I give permission for my data from this study to be shared with other researchers in the future provided that my anonymity is protected
- ☐ I understand that non-identifiable data from this study including quotations might be used in academic research reports or publications
- ☐ I am 18 years old or over

By clicking the 'next' button below I indicate that I understand what the study involves and I agree to take part. If I do not want to participate I can close this window/press the exit button.

Are you a church leader in the UK?

This survey is for **UK based church leaders** such as pastors, ministers, reverends, preachers, clergy, vicars, and rectors, for whom church leadership is their primary role. **Are you a church leader** (regardless of denomination)?

- ○ Yes, I am a UK church leader
- ○ Yes, I am a church leader outside of the UK
- ○ No, I am not a church leader

Your leadership

Are you a main or 'co' minister / leader?

- Main minister / leader (e.g. senior pastor)
- Co - minister (associate pastor)
- Youth pastor (or other title, where your main responsibility is care of the church youth)
- Other

If you selected Other, please specify:

In what denomination do you lead?

- Baptist
- Church of the Nazarene
- Other

If you selected Other, please specify:

Roughly how many congregants do you minister to?

Where do you serve?

- A rural community
- An urban community
- A mixed community
- Other

If you selected Other, please specify:

Roughly how many years have you served as a church leader?

Your time

Do you have contracted work hours?

Your time

How many hours a week do you work for the church in which you are actively engaged in **expected paid work activities**?

- 1 - 5
- 6 - 10
- 11 - 15
- 16 - 20
- 21 - 25
- 26 - 30
- 31 - 35
- 36 - 40
- 41 - 45
- 46 - 50
- 51 - 55
- 56 - 60
- Greater than 61 hours

How many hours a week are you **'on call'** for your church (i.e., time in which you could be called without prior notice outside your usual expected work hours)?

- 1 - 5
- 6 - 10
- 11 - 15
- 16 - 20
- 21 - 25
- 26 - 30
- 31 - 35
- 36 - 40
- 41 - 45
- 46 - 50
- 51 - 55
- 56 - 60
- Greater than 61 hours

How many hours a week do you engage in **unpaid work** for your church that is not part of your usual expected work hours (e.g., leading a house group or youth activity)?

- 1 - 5
- 6 - 10

- 11 - 15
- 16 - 20
- 21 - 25
- 26 - 30
- 31 - 35
- 36 - 40
- 41 - 45
- 46 - 50
- 51 - 55
- 56 - 60
- Greater than 61 hours

Your time

How many hours a week do you work for the church in which you are actively engaged in **paid work activities**?

- 1 - 5
- 6 - 10
- 11 - 15
- 16 - 20
- 21 - 25
- 26 - 30
- 31 - 35
- 36 - 40
- 41 - 45
- 46 - 50
- 51 - 55
- 56 - 60
- Greater than 61 hours

How many hours a week are you **'on call'** for your church (i.e., time in which you could be called without prior notice outside your usual work hours)?

- 1 - 5
- 6 - 10
- 11 - 15
- 16 - 20
- 21 - 25
- 26 - 30
- 31 - 35
- 36 - 40
- 41 - 45
- 46 - 50
- 51 - 55
- 56 - 60
- Greater than 61 hours

How many hours a week do you engage in **unpaid work** for your church that is not part of your usual work hours (e.g., leading a house group or youth activity)?

- 1 - 5
- 6 - 10

- 11 - 15
- 16 - 20
- 21 - 25
- 26 - 30
- 31 - 35
- 36 - 40
- 41 - 45
- 46 - 50
- 51 - 55
- 56 - 60
- Greater than 61 hours

Spiritual health

Please give **two responses** to each of the following items by selecting a response in **column A and column B.** Do not spend too much time on any one item, it is best to **record your first thoughts**.

1 = very low, **2** = low, **3** = moderate, **4** = high, **5** = very high.

	A - How important do you think each item is for an **ideal** state of **spiritual health**					**B - How you feel** each item reflects **your** personal experience most of the time				
	1	2	3	4	5	1	2	3	4	5
A love of other people	○	○	○	○	○	○	○	○	○	○
Personal relationship with the Divine / God	○	○	○	○	○	○	○	○	○	○
Forgiveness towards others	○	○	○	○	○	○	○	○	○	○
Connection with nature	○	○	○	○	○	○	○	○	○	○
A sense of identity	○	○	○	○	○	○	○	○	○	○
Worship of the Creator	○	○	○	○	○	○	○	○	○	○
Awe at a breath-taking view	○	○	○	○	○	○	○	○	○	○
Trust between individuals	○	○	○	○	○	○	○	○	○	○
Self-awareness	○	○	○	○	○	○	○	○	○	○
Oneness with nature	○	○	○	○	○	○	○	○	○	○

Spiritual health

Please give **two responses** to each of the following items by selecting a response in **column A and column B.** Do not spend too much time on any one item, it is best to **record your first thoughts**.

1 = very low, **2** = low, **3** = moderate, **4** = high, **5** = very high.

	A - How important do you think each item is for an **ideal** state of **spiritual health**					**B** - **How you feel** each item reflects **your** personal experience most of the time				
	1	2	3	4	5	1	2	3	4	5
Oneness with God	○	○	○	○	○	○	○	○	○	○
Harmony with the environment	○	○	○	○	○	○	○	○	○	○
Peace with God	○	○	○	○	○	○	○	○	○	○
Joy in life	○	○	○	○	○	○	○	○	○	○
Prayer life	○	○	○	○	○	○	○	○	○	○
Inner peace	○	○	○	○	○	○	○	○	○	○
Respect for others	○	○	○	○	○	○	○	○	○	○
Meaning in life	○	○	○	○	○	○	○	○	○	○
Kindness towards other people	○	○	○	○	○	○	○	○	○	○
A sense of 'magic' in the environment	○	○	○	○	○	○	○	○	○	○

In general, how would you rate your spiritual health?

	Excellent	Very good	Good	Fair	Poor
My spiritual health is	☐	☐	☐	☐	☐

Mental wellbeing

Please tick the box that best describes your experience of each area over the **past two weeks.**

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	☐	☐	☐	☐	☐
I've been feeling useful	☐	☐	☐	☐	☐
I've been feeling relaxed	☐	☐	☐	☐	☐
I've been dealing with problems well	☐	☐	☐	☐	☐
I've been thinking clearly	☐	☐	☐	☐	☐
I've been feeling close to other people	☐	☐	☐	☐	☐
I've been able to make up my own mind about things	☐	☐	☐	☐	☐

Do you have the opportunity for **regular clinical supervision**, counselling or other talking therapy for reflection regarding your job role? This would be provided by a qualified counsellor (or other practitioner) and is **not** mentorship via your church.

- ○ No
- ○ Yes - self-funded
- ○ Yes - church funded
- ○ Yes - funded by an outside agency
- ○ Yes - I have the opportunity but I do not use this service

Mental wellbeing

Thinking about work:

	Very Seldom	Seldom	Sometimes	Often	Very often or always
Do you become tense when you think about work-related issues during your free time?	☐	☐	☐	☐	☐
Are you annoyed by thinking about work-related issues when not at work?	☐	☐	☐	☐	☐
Are you irritated by work issues when not at work?	☐	☐	☐	☐	☐
Do you become fatigued by thinking about work-related issues during your free time?	☐	☐	☐	☐	☐
Are you troubled by work-related issues when not at work?	☐	☐	☐	☐	☐

Thinking about work:

	Very Seldom	Seldom	Sometimes	Often	Very often or always
After work I tend to think of how I can improve my work-related performance	☐	☐	☐	☐	☐
In my free time I find myself re-evaluating something I have done at work	☐	☐	☐	☐	☐
Do you think about tasks that need to be done at work the next day?	☐	☐	☐	☐	☐
I find thinking about work during my free time helps me to be creative	☐	☐	☐	☐	☐
I find solutions to work-related problems in my free time	☐	☐	☐	☐	☐

Thinking about work:

	Very Seldom	Seldom	Sometimes	Often	Very often or always
Do you feel unable to switch off from work?	☐	☐	☐	☐	☐
I am unable to stop thinking about work-related issues in my free time	☐	☐	☐	☐	☐
Do you find it easy to unwind after work?	☐	☐	☐	☐	☐
I make myself switch off from work as soon as I leave	☐	☐	☐	☐	☐
Do you leave work issues behind when you leave work?	☐	☐	☐	☐	☐

Thinking about socialising:

	Never	Less than once a month	Once a month	Several times a month	Once a week	Several times a week	Every day
How often do you meet socially with friends, relatives, or work colleagues?	☐	☐	☐	☐	☐	☐	☐

Not including paid professionals, do you have anyone with whom you can discuss intimate and personal matters?

- ○ Yes
- ○ No

In general, how would you rate your mental health?

	Excellent	Very good	Good	Fair	Poor
My mental health is	☐	☐	☐	☐	☐

Physical health

Please **select your height**. If you don't know your height, please give a close estimate.

Please **select your weight**. If you don't know your weight, please give a close estimate.

On a typical week, **how much time** do you spend in total on **moderate and vigorous physical activities** where your heartbeat increases and you breathe faster (e.g., brisk walking, cycling as a means of transport or as exercise, heavy gardening, running, or recreational sports). Only include activities that lasted at least 10 minutes at a time.

How many days per week do you do moderate / vigorous exercise of at least 10 minutes per session?

On a typical week, **how much time** do you spend in total on **strengthening activities** (e.g., lifting weights, working with resistance bands, doing exercises that use your own body weight such as push-ups and sit-ups, heavy gardening, such as digging and shovelling, yoga or Pilates)?

How many days per week do you do strengthening exercises?

Physical health

Your sleep - In the past **4 weeks**:

	Never or almost never	Less than once per week	On 1-2 days per week	On 3-5 days per week	Every night or almost every night
Have you had difficulties falling asleep?	☐	☐	☐	☐	☐
How often have you awakened during the night?	☐	☐	☐	☐	☐
How often have you awakened too early in the morning without being able to fall asleep again?	☐	☐	☐	☐	☐
Do you feel excessively sleepy in the morning after awakening?	☐	☐	☐	☐	☐
Do you feel excessively sleepy during the daytime?	☐	☐	☐	☐	☐

In the **last 5 years**, has your GP (or another physician) diagnosed you with any of the following conditions? Tick all that apply.

- ☐ None
- ☐ Coronary heart disease / cardiovascular disease (CHD)
- ☐ High cholesterol
- ☐ High blood pressure (hypertension)
- ☐ Stroke or mini stroke (CVA or TIA)
- ☐ Liver disease
- ☐ Respiratory disease (COPD, asthma, obstructive sleep apnoea)
- ☐ Type 2 diabetes
- ☐ Migraines or frequent headaches
- ☐ Gastrointestinal issues (e.g., IBS)
- ☐ Musculoskeletal issues (osteoarthritis, back pain, repetitive strain injury)
- ☐ Skin conditions such as Eczema
- ☐ Osteoarthritis, joint disorders including gout
- ☐ Gall stones
- ☐ Cancer including, lung, colon, breast, ovarian, prostate, liver, endometrial, renal, and rectal
- ☐ Chronic fatigue and immune disorders
- ☐ Stomach issues, pain bloating, nausea, vomiting, increased or decreased appetite
- ☐ Other

If you selected Other, please specify:

Please select your **usual diet**:

If you have a medical restriction such as a lactose, gluten or nut free diet, please select 'Other' and state your restriction alongside your main diet e.g., 'Gluten free and vegan'

- No restriction (standard unrestricted diet, consuming meat, fish, poultry, dairy, and eggs etc.)
- Flexitarian (consumes meat, fish, poultry, dairy, and eggs but significantly restricts consumption e.g., 'meat-free Mondays')
- Pescatarian / Pescetarian (consumes fish and seafood, but avoids meat, fish, poultry, dairy, and eggs)
- lacto-ovo-pescatarian (consumes fish, seafood, dairy, and eggs, but avoids meat, and poultry)
- Lacto-ovo vegetarian / standard vegetarian (does consume eggs and dairy, but avoids meat, fish and poultry)
- Lacto vegetarian (consumes dairy, but avoids meat, fish, poultry, and eggs)
- Ovo vegetarian (consumes eggs, but avoids meat, fish, poultry, and dairy)
- Vegan / fully plant based (avoids all animal based products such as meat, fish, poultry eggs, and dairy)
- Pollo-pescetarian (consumes poultry, fish, dairy, and eggs, but avoids meat from mammals)
- Pollotarian (consumes poultry, eggs, and dairy, but avoids meat and fish)
- Other

If you selected Other, please specify:

To what extent do you agree with the following?

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
On a typical day I consume sensible food portions for my gender, e.g., not filling the plate to the edges					
I am aware of where I get my basic nutrients from such as iron, protein, B12, calcium, fibre, vitamin C & D, fatty acids					
I am aware of the saturated fat, sugar, salt guidelines and generally stick to them					
I (or my family), cooks food from scratch, e.g., we do not use jar sauces or ready meals					

Physical health

For each listed food, please tick a box to indicate how often, **on average**, you have eaten the specified amount during the last **12 months**.

	Never	Less than once / month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once per day	2-3 per day	4-5 per day	6+ per day
Any kind of red meat, poultry, and eggs in any form (1egg) (i)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Oily fish (ii)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Meat and protein alternatives (iii)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Wholegrains (one slice, roll, small bowl or cup) (iv)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
White refined grains (one slice, roll, small bowl or cup) (v)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cheese any kind (1oz or 30g piece / matchbox size)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heavily processed foods and / or deep fried foods (vi)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

(i) Any kind of red meat including beef, lamb, pork, venison, liver (in any form e.g., sausages, burgers, bacon, mince, steak, corned beef, pate, ham luncheon meat etc.) in a medium serving. Any kind of poultry e.g., chicken, turkey, pheasant, goose, duck etc. (medium serving)

(ii) Oily fish including herring (bloater, kipper and hilsa) pilchards, salmon, sardines, sprats, trout, and mackerel (one medium fillet serving

(iii) Meat and protein alternatives such as Quorn, soya products e.g., tofu (medium serving), peas and legumes e.g., beans, baked beans, peas, lentils (medium serving), peanuts or other nuts (10 whole)

(iv) Wholegrains (one slice, roll, small bowl or cup) of wholegrain or wholemeal rice, pasta, bread or cereal.

(v) Refined grains (one slice, roll, small bowl or cup) of white, rice, pasta, bread including 50:50 or cereal.

(vi) Heavily processed foods such as pizza, ready meals, quiche, pies, pastries, chips, crisps or another packet snack e.g., cheese biscuits, fruit pies, cakes, tarts, sweet biscuits, Ice cream, chocolate (NOT including dark chocolate), sweets, toffees, salad dressing, condiments, jam, marmalade, cream including clotted, double and single, yoghurt. Deep fried foods such as chips, fish, sausage etc.

For each listed food, please tick a box to indicate how often, **on average**, you have eaten the specified amount during the last **12 months**.

	Never	Less than once / month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once per day	2-3 per day	4-5 per day	6+ per day
Sugar added to your tea, coffee or desserts (one teaspoon)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Salt added to food when cooking or once on the table	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fruits of any kind (one or one medium serving)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vegetables of any kind (one or one medium serving)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

In general, how would you rate your physical health?

	Excellent	Very good	Good	Fair	Poor
My physical health is	☐	☐	☐	☐	☐

About your job

Please indicate strength of agreement with each of the following statements.

	Strongly agree	Agree	Disagree	Strongly disagree
I always find new and interesting aspects in my work.	☐	☐	☐	☐
There are days when I feel tired before I arrive at work.	☐	☐	☐	☐
It happens more and more often that I talk about my work in a negative way.	☐	☐	☐	☐
After work, I tend to need more time than in the past in order to relax and feel better.	☐	☐	☐	☐
I can tolerate the pressure of my work very well.	☐	☐	☐	☐
Lately, I tend to think less at work and do my job almost mechanically.	☐	☐	☐	☐
I find my work to be a positive challenge.	☐	☐	☐	☐
During my work, I often feel emotionally drained.	☐	☐	☐	☐
Over time, one can become disconnected from this type of work.	☐	☐	☐	☐
After working, I have enough energy for my leisure activities.	☐	☐	☐	☐
Sometimes I feel sickened by my work tasks.	☐	☐	☐	☐
After my work, I usually feel worn out and weary.	☐	☐	☐	☐
This is the only type of work that I can imagine myself doing.	☐	☐	☐	☐
Usually, I can manage the amount of my work well.	☐	☐	☐	☐
I feel more and more engaged in my work.	☐	☐	☐	☐
When I work, I usually feel energized.	☐	☐	☐	☐

Thinking of your household's total monthly or weekly income, is your household able to **make ends meet**?

	Very easily / easily	Fairly easily	With some difficulty	With difficulty / with great difficulty
That is pay your usual expenses:	☐	☐	☐	☐

Do you hold any other jobs in order to supplement your church income?

37.a - Do you hold any other jobs in order to supplement your church income?

Yes, I have a second job where I am employed

Yes, I am self-employed in another role

No, I do not have any other form of employment

About your job

Do you feel you have 'permission' and are supported to take time out to care for your physical and mental health needs by:

	Yes, always	Yes, sometimes	Only on rare occasions	No, never
Your church leadership	☐	☐	☐	☐
Your church congregation	☐	☐	☐	☐

Do you feel caring for your physical and mental health is an important factor for your effectiveness in ministry?

- ○ Yes, definitely
- ○ Yes, but not as important as my spiritual health
- ○ Not really, only when I have time, energy etc.
- ○ Not at all important

About you

How old are you?

What gender do you identify with?

- ○ Male
- ○ Female
- ○ Other
- ○ Prefer not to say

What is your marital status?

- ○ Single
- ○ Married
- ○ In a registered partnership
- ○ Widowed
- ○ Separated
- ○ Divorced
- ○ Prefer not to say

Success, your responses have been submitted.

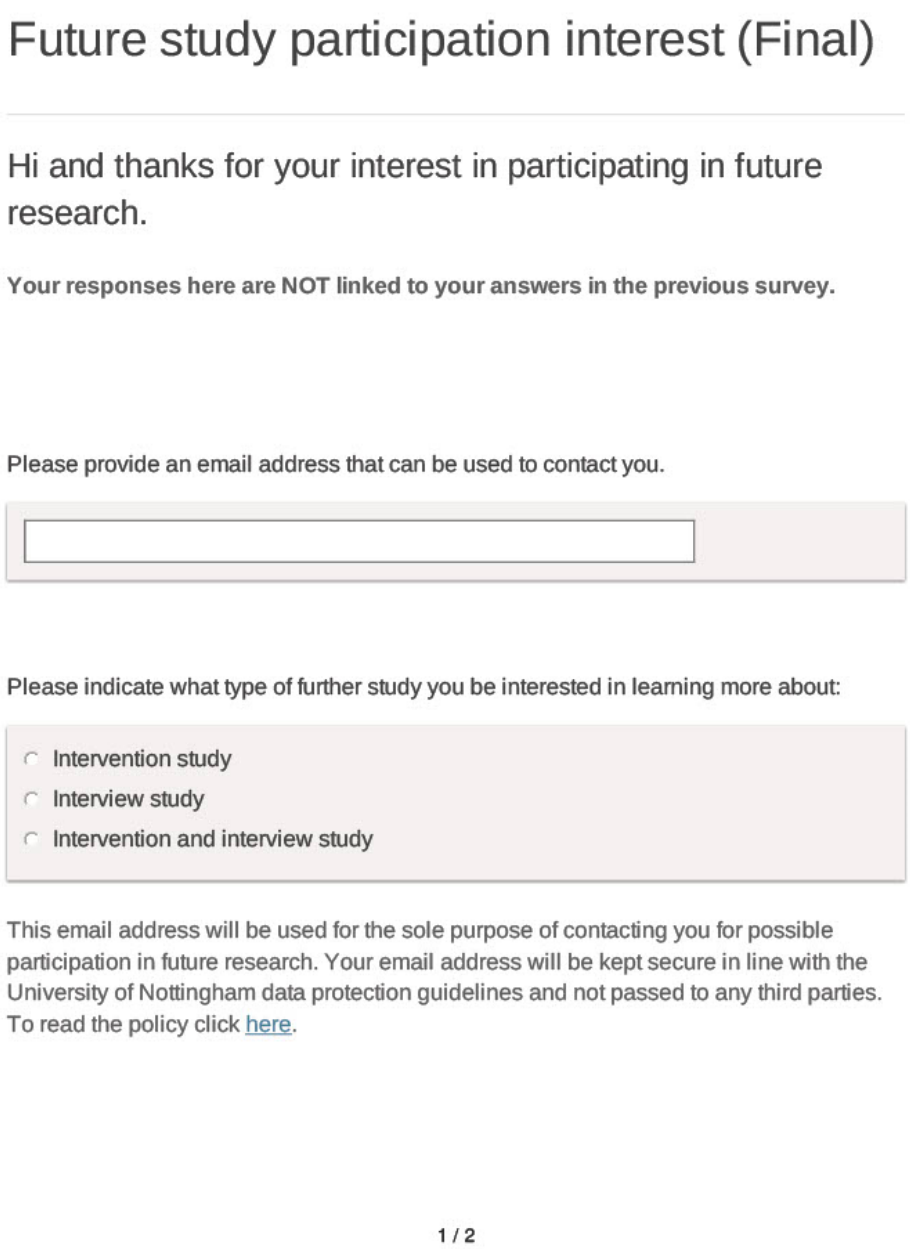
Want to take part in further research?

If you would like to sign up to be notified if we launch either an **intervention study** and / or hold focussed **interviews,** please click here. Please note this takes you to an entirely separate survey form, your responses **cannot** be linked.

Further support and information

If you have been affected by any of the items in this questionnaire and would like further information or support, please contact the following agencies:

Appendix D - Study One – Future Participation Interest Sign Up



Future study participation interest (Final)

Hi and thanks for your interest in participating in future research.

Your responses here are NOT linked to your answers in the previous survey.

Please provide an email address that can be used to contact you.

Please indicate what type of further study you be interested in learning more about:

- Intervention study
- Interview study
- Intervention and interview study

This email address will be used for the sole purpose of contacting you for possible participation in future research. Your email address will be kept secure in line with the University of Nottingham data protection guidelines and not passed to any third parties. To read the policy click here.

1 / 2

Submitted

Thanks, we have recorded your email. You can now close the survey.

If you have any questions, please contact Jamie Green on msxjg4@nottingham.ac.uk

Appendix E - Support Contacts List

University of Nottingham
UK | CHINA | MALAYSIA

School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

SUPPORT CONTACTS

Please find below a list of agencies and organisations which can assist with health, wellbeing, and job concerns:

Mental Health

Mind - https://www.mind.org.uk/
Mind has an array of help from articles and information, events, and likeminded online communities.

Samaritans - https://www.samaritans.org/
If you are in crisis Samaritans are there to help, remember you can call their free number any time day or night, 365 days a year.

Call 116 123 for free

If you are feeling suicidal or that you may harm yourself, please seek immediate help from your nearest A&E or dial 999.

Many forms of counselling and psychotherapy can be incredibly helpful, however, sometimes it can be easier to discuss issues you may have with someone who understands your spiritual perspective. To seek a Christian specific counsellor, try The Association of Christian Counsellors UK https://www.acc-uk.org/

Physical Health

NHS choices - https://www.nhs.uk
NHS choices has a list of local services such as your nearest GP and dentist. They also have a 'Link Listing' page for evidenced based support charities such as the 'Parent Zone', 'Pain Toolkit' and 'Living life to the full' etc.

Bupa Health A-Z - https://www.bupa.co.uk/health-information/a-to-z
This is a useful information site from Bupa with free health and wellbeing information for a wide range of health issues and conditions.

Spiritual Health

Crossline - https://www.crossline.org.uk
Trained Christians there to offer a listening ear whatever your issue. Call 9am to 12 midnight any day: 0300 111 0101 or email: prayer@crossline.karoo.co.uk

Chat Now - https://chatnow.org/chat/
Safe and confidential free online chat about all spiritual matters. Their website also has some useful advice on a variety of topics.

Work / job role concerns

Fresh Streams - https://freshstreams.net/
Fresh Streams runs regular events to support you in your ministry. Their website features some of their latest talks, articles, and upcoming events.

ACAS - https://www.acas.org.uk
For employment issues ACAS (The Advisory, Conciliation and Arbitration Service) is a free and impartial service that provides information and advice to employers and employees on all aspects of workplace relations and employment law.

The Fellowship of Independent Evangelical Churches - https://fiec.org.uk/resources
This website has helpful articles and practical advice around things like copyright, owning your church building, first aid, and other day to day tasks.

Appendix F - Study Two – Participant Information

University of Nottingham
UK | CHINA | MALAYSIA

School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

PARTICIPANT INFORMATION

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: What factors promote and hinder clergy health and wellbeing?

Student researcher: Jamie Green, msxjg4@nottingham.ac.uk

Supervisor: Jonathan Houdmont, jonathan.houdmont@nottingham.ac.uk

Ethics Reference Number: 1658

I would like to invite you to take part in a research study concerning perceived barriers and facilitators to the maintenance of physical, mental, spiritual, and social health among Baptist and Nazarene clergy. Before you begin, we would like you to understand why the research is being done and what it involves for you.

What is the purpose of this study?
Little is known about the wellbeing and self-care of Christian church leaders. The purpose of this study is to gain a deeper understanding of what promotes and prevents good health and wellbeing practices in UK Baptist and Nazarene clergy. The research is being conducted by Jamie Green as part of a PhD in occupational health psychology.

Whilst the study will not help you personally, the information derived from this study will contribute to the knowledge base and inform further research concerning the protection and promotion of clergy wellbeing.

Why have I been invited?
You have been invited because you are a member of the Baptist or Nazarene church clergy in the UK.

Do I have to take part?
It is up to you to decide whether or not to take part. And you may change your mind about being involved at any time or decline to discuss a particular question. You are free to withdraw at any point before or during the study without giving a reason. If you do decide to take part, you will be asked to give your consent beforehand.

What will I be asked to do?
If you choose to take part, the student researcher will arrange a mutually convenient date and time to have a private, recorded interview on Microsoft Teams lasting 30 – 45 minutes. During the interview you will be asked questions about factors that promote or hinder your health and wellbeing across the physical, mental, spiritual, and social domains.

Prior to the interview you will be asked to complete a brief online survey collecting basic demographic data such as age, sex, denomination, and years of service.
What will happen to the information I provide?

University of Nottingham
UK | CHINA | MALAYSIA

The interview recording will be transcribed by the student researcher within seven days. Any identifying information (such as names, specific locations, etc.) will be removed. The recording will then be destroyed. All data will be stored securely on password-protected facility that only the student researcher and her supervisor will have access to.

As this research forms part of the student researcher's PhD, anonymised interview transcripts may be viewed by examiners both at the University of Nottingham and externally. Anonymised data may also be used in academic journal articles and conference presentations. Your anonymity will be protected in any quotes used from interviews; however, if you do not wish us to use quotes from your interview please, please tell the student researcher.

Should you wish to receive a summary of the results please contact the student researcher in the Autumn of 2021.

Are there any possible disadvantages or risks in taking part?

This study discusses topics surrounding health that some may find sensitive. Should participation raise issues you would like to discuss with a trained professional please seek advice from your GP or refer to the following links:
Mind - https://www.mind.org.uk/
Samaritans - https://www.samaritans.org/
As with any online activity the risk of a breach is always possible. We will do everything possible to ensure your interview responses remain anonymous.

Data Protection

We will follow ethical and legal practice and all information will be handled in confidence. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:
https://www.nottingham.ac.uk/utilities/privacy.aspx

We would like your permission to use anonymised data in future studies, and to share our research data (e.g. in online databases) with other researchers in other Universities and organisations both inside and outside the European Union. This would be used for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

University of Nottingham
UK | CHINA | MALAYSIA

At the end of the project, all raw data will be kept securely by the University under the terms of its data protection policy after which it will be disposed of securely. The data will not be kept elsewhere.

If you have any questions or concerns, please don't hesitate to ask. We can be contacted before and after your participation at the email addresses above.

What if there is a problem?
If you have any queries or complaints, please contact the student's supervisor/chief investigator in the first instance. If this does not resolve your query, please write to the Administrator to the Division of Psychiatry & Applied Psychology's Research Ethics Sub-Committee adrian.pantry@nottingam.ac.uk who will pass your query to the Chair of the Committee.

If you remain unhappy and wish to complain formally, you should then contact the Faculty of Medical and Health Sciences Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk

Appendix G - Study Two – Interview Consent and Demographics Survey

Clergy Health and wellbeing interviews - demographics (Final)

Page 1: Welcome

Thank you for your interest.

Below you will find the information for participants.

To participate, start by answering the consent questions at the bottom of this page.

Download the full **Participant Information** here.

What is the purpose of this study?

The purpose of this study is to gain an understanding of what prevents and promotes good health and wellbeing in practicing clergy.

Why have I been invited?

You have been invited because you work as a pastor / minister (or other title) where church leadership is your primary job role.

What will I be asked to do?

If you choose to take part, simply complete this online questionnaire which details your demographic information, and where you can specify a date and time for your interview. This questionnaire should take no longer than 5 minutes.

You will then be sent a Teams invite to participate in a 30 - 45 minute, private, recorded interview. Here we will discuss your thoughts and feelings about your health and wellbeing.

Do I have to take part?

It is up to you to decide whether or not to take part. You are free to withdraw at any point

before or during the study without giving a reason.

Will the research be of any personal benefit to me?

We cannot promise the study will help you personally, but information gained from this study may inform future developments in the promotion of UK clergy health and wellbeing.

Are there any possible disadvantages or risks in taking part?

This study discusses topics surrounding health that some may find sensitive. Details of health and wellbeing support services are given at the end of this questionnaire.

What will happen to the information I provide?

Responses to this questionnaire will be linked to the interview recordings for data analysis. Interview recordings will be transcribed and anonymised, after which the recordings will be destroyed.

This piece of research forms part of a PhD project. Anonymised transcripts will be assessed by supervisors and examiners both at the University of Nottingham and externally. Anonymised, data will also feature in an academic journal article which may be published and read by the general public.

To participate, start by answering the consent questions below.

Please answer all questions honestly, these questions will help with data analysis after your interview, your anonymity will be protected.

Please select each statement to show you agree with the following:

- ☐ I have read and understood the Participant Information
- ☐ I agree to take part in the interview, that will be recorded, about clergy self-care
- ☐ I agree to complete the questionnaire about my demographic information which will be linked to my interview
- ☐ I understand that once I have been interviewed and the recording has been transcribed (within 7 days) it may not be technically possible to withdraw my data

- [ ] I know how to contact the student researcher if I have questions about this study
- [ ] I understand that I am free to withdraw from the study without giving a reason
- [ ] I give permission for my data from this study to be shared with other researchers in the future provided that my anonymity is protected
- [ ] I understand that non-identifiable data from this study including quotations might be used in academic research reports or publications
- [ ] I am 18 years old or over

By clicking the 'next' button below I indicate that I understand what the study involves and I agree to take part. If I do not want to participate, I can close this window/press the exit button.

Page 2: Denomination

In what denomination do you lead?

- ○ Baptist
- ○ Church of the Nazarene
- ○ Other

Page 3: About you

What is your name? (We use this to pair your answers to your interview)

What is your email address? (We use this to set up a private Teams meeting for the interview)

How old are you?

What gender do you identify with?

- Male
- Female
- Other
- Prefer not to say

What is your marital status?

- Single
- Married

- In a registered partnership
- Widowed
- Separated
- Divorced
- Prefer not to say

Page 4: Your leadership

Are you a main or 'co' minister / leader?

- Main minister / leader (e.g., senior pastor)
- Co - minister (associate pastor)
- Youth pastor (or other title, where your main responsibility is care of the church youth)
- Other

If you selected Other, please specify:

Roughly how many years have you served as a church leader?

Page 5: Your health

How would you rate your health in the following areas:

	Very poor	Poor	Fair	Good	Excellent
Physical health					
Mental health					
Spiritual health					
Social health					

Page 6: Date and time for your interview

The interview will last between 35 and 45 minutes. Please choose 3 convenient dates and times for your interview. **Only one date and time will be chosen by the interviewer**. You will be notified by email of the chosen date and time.

First choice:

More info

(dd/mm/yyyy hh:mm)

Second choice:

(dd/mm/yyyy hh:mm)

Third choice:

(dd/mm/yyyy hh:mm)

Page 7: Success, your responses have been submitted.

Want to take part in further research?

If you would like to sign up to be notified if we launch an **intervention study,** please click here. Please note this takes you to an entirely separate survey form, your responses **cannot** be linked.

Further support and information

If you would like further information or support on aspects of health and wellbeing, please contact the following agencies:

Appendix H - Study Two – Future Intervention Interest Survey

Future intervention study participation interest (Final)

Hi and thanks for your interest in participating in future research.

Your responses here are NOT linked to your answers in the previous survey.

Please provide an email address that can be used to contact you.

Please indicate in what denomination do you lead?

- Baptist
- Church of the Nazarene

This email address will be used for the sole purpose of contacting you for possible participation in future research. Your email address will be kept secure in line with the University of Nottingham data protection guidelines and not passed to any third parties. To read the policy click here.

Submitted

Thanks, we have recorded your email. You can now close the survey.

If you have any questions, please contact Jamie Green on msxjg4@nottingham.ac.uk

Appendix I - Stage Two – Interview Schedule

Study Title: Baptist and Nazarene Church Clergy Self-Care: A Qualitative Investigation of Perceived Barriers and Facilitators

INTERVIEW SCHEDULE

Welcome - Thanks for taking the time to speak with me today. We're here to talk about clergy health and wellbeing. I'm going to ask questions about aspects of health and wellbeing; specifically, what helps and what hinders your health.

Confidentiality - Our discussion is completely confidential. Please answer the questions as honestly as you can. **There are no right or wrong answers**.

Recording – This session will be recorded. The recording will be transcribed within seven days of today's interview, with any identifying information removed. The recording will then be deleted.

Time – The interview will last between 30 and 45 minutes. It is important that you feel as comfortable as possible; if you have any questions or need a break at any point please let me know.

Main questions	**Prompts**
Let's start by having you briefly describe your current role.	○ What does your average week look like? ○ Do you have set breaks and downtime? ○ Do you have a weekly routine?
This study is about health and wellbeing. Some of us may live with physical or mental differences or disabilities and our 'normal' or 'best' health may not look the same as the average person but is normal for us. With this in mind, lets discuss health and wellbeing a little more closely.	
What does health mean to you?	○ At work – how does it influence your daily work? ○ Homelife, As a Christian, As a minister ○ Is health important, if not, why not? ○ In relation to ministry, do you ever discuss health and wellbeing with peers / other clergy?
Next, we are going to look at some specific aspects of health.	
What, if anything, hinders or prevents you from looking after your physical health? (i.e. the physical body)	○ What specifically puts you off looking after your physical health (time, cost, family pressure, lack of interest etc) ○ How has COVID-19 impacted your health ○ What frustrates you in looking after your health ○ Attitudes of others
What helps you maintain your physical health?	○ Have you ever engaged in any ministry-based health programs? ○ Have you had any guidance or training pre-post? ○ Do you use any equipment, apps, coaching, supports? ○ Do you have a health routine, habits, strategy or plan? ○ What about longevity of life, potential disability and illness? ○ Do you know how or where you could get support / help in this area? ○ What helps you sustain these health habits? ○ What would encourage you to look after your physical health more? What would motivate you, apps, a mentor, a 6 week program etc. ○ Do you feel supported in looking after your physical health? What supports would you like to see? ○ How easy / difficult do you find looking after your health?

Main questions	Prompts
	○
What, if anything, hinders or prevents you from looking after your mental health?	(i.e. your sense of mental wellbeing, feelings of being emotionally level, understood, valued, respected, heard, stress levels, lack of mental illness Or stable mental illness)
What helps you maintain your mental health?	• Clinical supervision / counselling? • Does your church have any health and wellbeing policies (beyond usual safeguarding)
What, if anything, hinders or prevents you from looking after your spiritual health?	(i.e. your relationship with God, prayer life, sense of meaning in the bigger picture)
What helps you maintain your spiritual health?	• Do you think the church (hierarchy and congregation) has a place in supporting the health of their ministers?
What, if anything, hinders or prevents you looking after your social health?	(i.e. your relationships outside of work, your friends, that sense of true and fulfilling mutually beneficial connection with others)
What helps you maintain your social health?	
Thinking about health and wellbeing in general, do you feel being healthy, e.g. looking after your body and mind, is required of a Christian and of a minister?	○ What do you feel the bible says about physical health and being a follower of Christ / minister? ○ In your experience, what are the benefits of health for ministry? ○ Do you think there is a culture of health in ministry? Is this encouraged / discouraged?
Finally, if you could improve one area of your health, in any area, what would it be? **If we were to create an educational intervention about this, what would make it appealing to you?**	○ What would you like to see improve for you in the future? e.g. ○ Drink more water ○ Sleep better ○ Manage my time more effectively ○ Pray more ○ Start running ○ Keep a mood journal ○ Express my feelings better ○ Be more emotionally genuine with my family ○ Spend more quality time with friends
That concludes my questions, thank you very much for your time. Do you have any questions? If you feel comfortable, I would appreciate you sharing the study advert with other clergy colleagues. Your participation today is greatly appreciated. Thanks, and enjoy the rest of your day.	

Appendix J - Systematised Literature Review Search Strategy

Databases identified from NU-search psychology database list:

APA PsycINFO (available via NU subscription)

MedLine - *MEDLINE is the largest component of PubMed.*

Scopus (includes Mendeley)

Proquest

Web of science

Year 2001 -2021

Search terms were identified by examining each word in the search question and its synonyms.

Question *Systematic review of health and wellbeing interventions in Christian clergy*

Population - Christian clergy

Intervention - Health and wellbeing interventions (any or all facet/s of health)

Comparison – Measurable change in health behaviours / health outcomes, behavioural model or areas of physical / mental health e.g. BMI

Outcome – behaviour or health outcome change

Run searches for Subject headings AND a multipurpose keyword search.

Clergy + (Health or wellbeing) + Intervention (then filter by 2001 – current)

First run .mp. search for each of the following terms:

1. Health
2. Wellbeing (well-being)
3. Intervention (Program)
4. Christian
5. Clergy (Pastor)

The first lines were text ran through Medline OVID producing 763 results including many irrelevant titles. To refine the search for a systematised approach search lines were edited to remove words which drew inappropriate results.

P –

Christ* or Religious or Evangelic* or Apostolic or Spirit* or Ecclesiastical or Pastoral or Holy or Minister* or Ecumenical* or Faith-based or Faith Based

Christ* or Faith-based or Faith Based

AND

Clergy or Church leader* or Vicar or Vicars or Pastor or Pastors or Minister or Ministers or Cleric or Clerics or Rabbi or Rabbis or Messianic Jew or Messianic Jews or Preacher* or Monk or Monks or Rector or Rectors or Chaplain or Chaplains or Bishop*

Clergy* or Church leader* or Vicar or Vicars or Pastor or Pastors

I -

Health or Health* or Fitness or Strength or Energy or Exercis* or Physical

Health or Health* or (health adj3 behavi?ur) or (health adj3 holistic)

Health or Health* or (health adj3 behavi?ur) or (health adj3 holistic) or (health adj3 resources) or Clergy health or Physical Activity

Health or Health* or (health adj3 behavi?ur) or (health adj3 holistic) or (health adj3 resources) or (Clergy adj3 health) or Physical Activity

Health or Health* or (health adj3 behavi?ur) or (health adj3 holistic) or (health adj3 resources) or (Clergy adj3 health) or Physical Activity or (Clergy adj3 Resources)

AND

Wellbeing or well-being or Welfare or Happiness or Safety or Security or Vigour or Wholeness or Holistic or Prosperity or Contentment or Wellness or Behavi?ur or Demands

Wellbeing or well-being or Welfare or Wholeness or Holistic or Wellness or (wellbeing adj3 behavi?ur) or (well-being adj3 behavi?ur)

Wellbeing or well-being or Welfare or Wholeness or Holistic or Wellness or (wellbeing adj3 behavi?ur) or (well-being adj3 behavi?ur) or Demands or Resources

AND

Intervention* or Intercession* or Mediation* or Trial* or Research or Investigation* or Experiment* or Program? or Schedule or Procedure or Campaign* or Therap* or Activit*

Intervention* or Investigation* or Program* or Programme* or Campaign* or Activity or Activities

Intervention* or Investigation* or Program* or Programme* or (Program ADJ3 Clergy) or (Programme ADJ3 Clergy) or Campaign* or Activity or Activities

Intervention* or Investigation* or Program* or Programme* or (Program ADJ3 Clergy) or (Programme ADJ3 Clergy) or Campaign* or Activity or Activities or Pilot

Intervention* or Investigation* or Program* or Programme* or (Program ADJ3 Clergy) or (Programme ADJ3 Clergy) or Campaign* or Activity or Activities or Pilot or Provision

O –

Behavi?ur Change or Health Change or Health Improvement or Health Behavi?ur or Health literacy or Health status or (Health ADJ3 Attitude) or Health resources or Results

(Behavi?ur ADJ3 Change) or (Health ADJ3 Change) or (Health ADJ3 Improvement) or Health status or (Health ADJ3 Attitude) or Health resources or Result*

Notes – '*' denotes truncation. '?' is used where spelling variations may occur. 'adj3' is used to locate articles where two key words are adjacent to each other separated by three or fewer words. 'or' is used to return results with one keyword only. 'AND' is used to combine searches carried out separately, e.g., 'Christ* or Faith-based or Faith Based' is first ran, then combined with a second search 'Clergy* or Church leader* or Vicar or Vicars or Pastor or Pastors'.

Appendix K - Systematised Literature Review Outputs

Search history sorted by search number ascending

#	Searches	Results	Type	Actions	Annotations
1	exp Health Equity/ or exp Holistic Health/ or Health/ or exp Health Status Disparities/ or exp Learning Health System/ or exp Health Communication/ or exp Health Education/ or exp Health Plan Implementation/ or exp Women's Health/ or exp Preventive Health Services/ or exp Health Knowledge, Attitudes, Practice/ or exp Public Health Nursing/ or exp "Social Determinants of Health"/ or exp Occupational Health Nursing/ or exp "Delivery of Health Care"/ or exp Health Promotion/ or exp Health Benefit Plans, Employee/ or exp "Quality of Health Care"/ or exp Health Impact Assessment/ or exp Health Fairs/ or exp Mental Health Services/ or exp Health Priorities/ or exp Health Literacy/ or exp Health Behavior/ or exp Occupational Health Services/ or exp Mental	10479349	Advanced	Display Results More	

		Health/ or exp Health Belief Model/ or exp Consumer Health Information/ or exp Health Surveys/ or exp Health Care Surveys/ or exp Occupational Health/ or exp Health Status Indicators/ or exp Population Health/ or exp Community Health Services/ or exp Health Resources/ or exp Community Mental Health Services/ or exp "Delivery of Health Care, Integrated"/ or exp Health Policy/ or exp Community Health Planning/ or exp Health Risk Behaviors/ or exp Comprehensive Health Care/ or exp Attitude to Health/ or exp Public Health/ or Health.mp. or exp Health Planning/ or exp Health Workforce/ or exp Health Status/			
☐	2	(Health or Health* or Fitness or Strength or Energy or Exercis* or Physical).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	5752397	Advanced	Display Results More

☐	3	1 or 2	12255377	Advanced	Display Results More
☐	4	exp "Quality of Life"/ or exp Adult/ or exp "Surveys and Questionnaires"/ or wellbeing.mp. or exp Mental Disorders/	8536484	Advanced	Display Results More
☐	5	(Wellbeing or wellbeing or Welfare or Happiness or Safety or Security or Vigour or Wholeness or Holistic or Prosperity or Contentment or Wellness or Behavi?ur or Demands).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	1101984	Advanced	Display Results More
☐	6	4 or 5	9240501	Advanced	Display Results More
☐	7	Intervention.mp. or exp Early Intervention, Educational/ or exp Internet-Based	673038	Advanced	Display Results More

		Intervention/ or exp Early Medical Intervention/ or exp Psychosocial Intervention/			
☐	8	(Intervention* or Intercession* or Mediation* or Trial* or Research or Investigation* or Experiment* or Program? or Schedule or Procedure or Campaign* or Therap* or Activit*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	18770395	Advanced	Display Results More
☐	9	Christian.mp. or exp Christianity/ or exp Adult/	7467245	Advanced	Display Results More
☐	10	(Christ* or Religious or Evangelic* or Apostolic or Spirit* or Ecclesiastical or Pastoral or Holy or Minister* or Ecumenical* or Faith-based or Faith Based).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word,	94677	Advanced	Display Results More

		keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]			
☐	11	7 or 8	18770395	Advanced	Display Results More
☐	12	9 or 10	7521785	Advanced	Display Results More
☐	13	exp "Religion and Psychology"/ or exp Clergy/ or Clergy.mp.	18897	Advanced	Display Results More
☐	14	(Clergy or Church leader* or Vicar or Vicars or Pastor or Pastors or Minister or Ministers or Cleric or Clerics or Rabbi* or Messianic Jew or Messianic Jews or Preacher* or Monk* or Rector or Rectors or Chaplain or Chaplains or Bishop*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism	497576	Advanced	Display Results More

		supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]			
☐	15	13 or 14	512850	Advanced	Display Results More
☐	16	3 and 6 and 11	4138213	Advanced	Display Results More
☐	17	12 and 15	41067	Advanced	Display Results More
☐	18	16 and 17	12908	Advanced	Display Results More
☐	19	#18.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare	665790	Advanced	Display Results More

		disease supplementary concept word, unique identifier, synonyms]			
☐	20	limit 18 to (english language and full text and yr="2001 -Current")	990	Advanced	Display Results More
☐	21	(Behavi?ur Change or Health Change or Health Improvement or Health Behavi?ur or Health literacy or Health status or (Health adj3 Attitude) or Health resources or Results).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	9565555	Advanced	Display Results More
☐	22	exp "Surveys and Questionnaires"/ or exp Health Status/ or health change.mp.	1329543	Advanced	Display Results More

☐	23	21 or 22	10035274	Advanced	Display Results More
☐	24	20 and 23	763	Advanced	Display Results More

Save Remove Combine with: AND OR

Appendix L - Intervention – Participant Information

University of Nottingham
UK | CHINA | MALAYSIA

School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

PARTICIPANT INFORMATION

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Baptist clergy health and wellbeing intervention

Researcher/Student: Mrs Jamie Green Jamie.green@nottingham.ac.uk

Supervisor/Chief Investigator: Dr Jonathan Houdmont Jonathan.houdmont@nottinghm.ac.uk

Ethics Reference Number: 2849

We would like to invite you to take part in a research study about Baptist clergy health and wellbeing. Before you begin, we would like you to understand why the research is being done and what it involves for you.

What is the purpose of this study?
There is little published research into the health and wellbeing of Baptist church leaders. This study aims to explore the feasibility of an intervention to promote clergy health and wellbeing. The research is being conducted by Jamie Green as part of a PhD in occupational health psychology.

We cannot promise the study will help you, but the information derived from this study will contribute to the knowledge base and inform further research concerning the protection and promotion of clergy wellbeing.

Why have I been invited?
You have been invited because you are a clergy member of the Baptist church in the UK affiliated with the Baptist Union of Great Britain (BUGB).

Do I have to take part?
It is up to you to decide whether or not to take part. You may change your mind about being involved at any time or decline to take part in any part of the study. You are free to withdraw at any point before or during the study without giving a reason. If you withdraw, it may not be possible to withdraw your data as your name will not be attached to your anonymous survey responses. We will not be collecting any personally identifiable information. If you decide to take part, you will be asked to give your consent beforehand.

What will I be asked to do?
You will be invited to complete a brief (5 minute) online survey that seeks your consent to participate in the study, collects basic non-identifiable demographic data, and asks you to rate your current health and intention to change your health behaviours.

You will then be invited to participate in a 90-minute online session that explores clergy self-care from a scriptural and scientific standpoint. The session involves an initial input from the student researcher (a registered nurse, a national health and wellbeing trainer, and a fellow of Advance

University of Nottingham
UK | CHINA | MALAYSIA

HE, the British higher education growth, support, and development organisation), a self-reflection activity, and group discussion. The session ends with a further brief (5-minute) anonymous online survey to explore whether your health behaviour intentions have changed as a result of participation in the session and gathers feedback on the acceptability and feasibility of the session for wider use among Baptist clergy.

What will happen to the information I provide?
Data from the two anonymous surveys will be stored in accordance with the University of Nottingham data protection, and ethics policies. No person identifiable data will be collected. These responses will be used to explore the effectiveness and suitability of the intervention session.

As this research forms part of the student researcher's PhD, anonymised project data may be viewed by examiners both at the University of Nottingham and externally. Anonymised data may also be used in academic journal articles and conference presentations. Your anonymity will be protected in any quotes used from feedback; however, if you do not wish us to use quotes from your final feedback, please tell the student researcher.

Should you wish to receive a summary of the results please contact the student researcher in the winter of 2022.

Are there any possible disadvantages or risks in taking part?
This study discusses topics surrounding health that some may find sensitive. Should participation raise issues you would like to discuss with a trained professional please seek advice from your GP or refer to the following links:
Mind - https://www.mind.org.uk/
Samaritans - https://www.samaritans.org/

As with any online activity the risk of a breach is always possible. We will do everything possible to ensure your participation remain anonymous.

Data Protection
We will follow ethical and legal practice and all information will be handled in confidence.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx

We would like your permission to use anonymised data in future studies, and to share our research data (e.g. in online databases) with other researchers in other Universities and organisations both inside and outside the European Union. This would be used for research in

University of Nottingham
UK | CHINA | MALAYSIA

health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

At the end of the project, all raw data will be kept securely by the University under the terms of its data protection policy after which it will be disposed of securely. The data will not be kept elsewhere.

If you have any questions or concerns, please don't hesitate to ask. We can be contacted before and after your participation at the email addresses above.

What if there is a problem?
If you have any queries or complaints, please contact the student's supervisor/chief investigator in the first instance. If this does not resolve your query, please write to the Administrator to the Division of Psychiatry & Applied Psychology's Research Ethics Sub-Committee adrian.pantry@nottingam.ac.uk who will pass your query to the Chair of the Committee.

If you remain unhappy and wish to complain formally, you should then contact the Faculty of Medical and Health Sciences Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk

We believe there are no known risks associated with this research study; however, as with any online activity the risk of a breach is always possible. We will do everything possible to ensure your answers in this study will remain anonymous.

Appendix M – Intervention Surveys

Pre-intervention Survey

Clergy health and wellbeing - feasibility intervention part 1 (Final)

Page 1: Welcome

Thank you for your interest.

Below you will find the information for participants.

To participate, start by answering the consent questions at the bottom of this page.

Download the full **Participant Information** here.

What is the purpose of this study?

This study aims to explore the feasibility of an intervention aimed at improving facets of clergy health and wellbeing.

Why have I been invited?

You have been invited because you work as a Baptist pastor / minister (or other title) where church leadership is your primary job role.

What will I be asked to do?

If you choose to take part, you will be invited to a 90-minute session where you will be asked to engage in 5 parts:

1. **Baseline questionnaire** - This short questionnaire (5-mins)
2. **Information sharing** – A short education session aimed at promoting reflection on your current self-care practices.
3. **Self-Reflection** – Based on the information session you will be asked to reflect on your own health and wellbeing, in particular areas of difficulty / struggle.
4. **Group work** – Participants will be asked to share and discuss common problems, seeking resolutions, and mitigation.

5. **Exit questionnaire** – Based on your experience, you will be asked to complete a short questionnaire on how suitable you feel the session was. (5-mins)

Do I have to take part?

It is up to you to decide whether or not to take part. You are free to withdraw at any point before or during the study without giving a reason.

Will the research be of any personal benefit to me?

We cannot promise the study will help you personally, but information gained from this study may inform future developments in the promotion of UK clergy health and wellbeing.

Are there any possible disadvantages or risks in taking part?

This study discusses topics surrounding health that some may find sensitive. Details of health and wellbeing support services are given at the end of this questionnaire.

What will happen to the information I provide?

Anonymous questionnaires from the start and end of the 90-minute session will be stored in accordance with the University of Nottingham data protection, and ethics policies. No person identifiable data will be collected. These responses will be used to explore the effectiveness and suitability of the intervention session.

This piece of research forms part of a PhD project. Responses will be assessed by supervisors and examiners both at the University of Nottingham and externally. Anonymised, data will also feature in an academic journal article which may be published and read by the general public.

To participate, start by answering the consent questions below.

Please answer all questions honestly, these questions will help with data analysis after the seminar session, your anonymity will be protected.

Please select each statement to show you agree with the following:

- [ ] I have read and understood the Participant Information
- [ ] I agree to take part in a feasibility health and wellbeing intervention about Baptist clergy health and wellbeing
- [ ] I agree to complete the questionnaires both before and after the session about my demographic information, self-rated health, and session experience
- [ ] I know how to contact the student researcher if I have questions about this study
- [ ] I understand that I am free to withdraw from the study without giving a reason
- [ ] I understand that once I have taken part it may not be technically possible to withdraw my data
- [ ] I give permission for my data from this study to be shared with other researchers in the future provided that my anonymity is protected
- [ ] I understand that non-identifiable data from this study including quotations might be used in academic research reports or publications
- [ ] I am 18 years old or over

By clicking the 'next' button below I indicate that I understand what the study involves and I agree to take part. If I do not want to participate, I can close this window to exit.

Page 2: About you

Please design a unique reference number. We will use this to pair your answers before and after the seminar session. To do this, use the last 3 numbers and letters of your postcode and the last 3 numbers of your phone number e.g., DH4 **7NQ** & 07725746**825** Becomes **7NQ825**

How old are you?

What gender do you identify with?

- Male
- Female
- Other
- Prefer not to say

What is your marital status?

- Single
- Married
- In a registered partnership
- Widowed
- Separated
- Divorced

- Prefer not to say

Page 3: Your leadership

Are you a main or 'co' minister / leader?

- Main minister / leader (e.g., senior pastor)
- Co - minister (associate pastor)
- Youth pastor (or other title, where your main responsibility is care of the church youth)
- Other

If you selected 'Other', please specify:

Roughly how many years have you served as a church leader?

Page 4: Your health part 1 of 2

How would you rate your health in the following areas:

	Very poor	Poor	Fair	Good	Excellent
Physical health					
Mental health					
Spiritual health					
Social health					

Page 5: Your health part 2 of 2

Thinking about your self-care in general do you already, or plan to, do anything to support your **physical health**?

e.g., You may have started jogging recently, so you may wish to choose *Yes, I have been doing 'X' regularly, but for less than 6 months.*

	Yes, I have been doing 'X' regularly for more than 6 months	Yes, I have been doing 'X' regularly, but for less than 6 months.	I used to do 'X' regularly but have stopped in the last 6 months.	No, but I intend to do regular 'X' in the next 30 days	No, but I have contemplated doing regular 'X' in the next 6 months	No, and I do not intend to do regular 'X' in the next 6 months
Physical health	○	○	○	○	○	○

If you selected "I used to do 'X' regularly but have stopped in the last 6 months" why was this?

Thinking about your self-care in general do you already, or plan to, do anything to support your **mental health**?

e.g., You may wish to try mindfulness but haven't yet got around to it. Here you may wish to select *No, but I intend to do regular 'X' in the next 30 days.*

	Yes, I have been doing 'X' regularly for more than 6 months	Yes, I have been doing 'X' regularly, but for less than 6 months.	I used to do 'X' regularly but have stopped in the last 6 months.	No, but I intend to do regular 'X' in the next 30 days	No, but I have contemplated doing regular 'X' in the next 6 months	No, and I do not intend to do regular 'X' in the next 6 months
Mental health	○	○	○	○	○	○

If you selected "I used to do 'X' regularly but have stopped in the last 6 months" why was this?

Thinking about your self-care in general do you already, or plan to, do anything to support your **spiritual health**?

e.g., If you are already doing a regular activity that successfully supports your health, e.g., a prayer routine for spiritual health, you may wish to select *Yes, I have been doing 'X' regularly for more than 6 months.*

	Yes, I have been doing 'X' regularly for more than 6 months	Yes, I have been doing 'X' regularly, but for less than 6 months.	I used to do 'X' regularly but have stopped in the last 6 months.	No, but I intend to do regular 'X' in the next 30 days	No, but I have contemplated doing regular 'X' in the next 6 months	No, and I do not intend to do regular 'X' in the next 6 months
Spiritual health	○	○	○	○	○	○

If you selected "I used to do 'X' regularly but have stopped in the last 6 months" why was this?

Thinking about your self-care in general do you already, or plan to, do anything to support your **social health**?

e.g., You may not wish to try anything new, or indeed have time to do so. For example, you may know regular coffee dates with friends revitalise you, but at the moment you do not have the time or mental space to organise this. Here you may wish to select *No, and I do not intend to do regular 'X' in the next 6 months.*

	Yes, I have been doing 'X' regularly for more than 6 months	Yes, I have been doing 'X' regularly, but for less than 6 months.	I used to do 'X' regularly but have stopped in the last 6 months.	No, but I intend to do regular 'X' in the next 30 days	No, but I have contemplated doing regular 'X' in the next 6 months	No, and I do not intend to do regular 'X' in the next 6 months
Social health	○	○	○	○	○	○

If you selected "I used to do 'X' regularly but have stopped in the last 6 months" why was this?

Page 6: Success, your responses have been submitted.

Further support and information

If you would like further information or support on aspects of health and wellbeing, please contact the following agencies:

Post-intervention Survey

Clergy health and wellbeing - feasibility intervention part 2 (Final)

Page 1: Welcome back

Welcome to part 2

In this short questionnaire we want to explore the impact of the session on you. We will ask you about self-care behaviours once again, and how you found the session in general. There are no right or wrong answers. To get started click next below.

Page 2: Your unique reference number

Please enter your unique reference number. You created this in the last questionnaire. This was the last 3 numbers and letters of your postcode, and the last 3 numbers of your phone number e.g., DH4 **7NQ** & 07725746**825** Becomes **7NQ825**

Page 3: Your health

Having now attended the session, please consider your self-care support strategies for **physical health** once again.

e.g., You may have started jogging recently, so you may wish to choose *Yes, I have been doing 'X' regularly, but for less than 6 months.*

	Yes, I have been doing 'X' regularly for more than 6 months	Yes, I have been doing 'X' regularly, but for less than 6 months.	I used to do 'X' regularly but have stopped in the last 6 months.	No, but I intend to do regular 'X' in the next 30 days	No, but I have contemplated doing regular 'X' in the next 6 months	No, and I do not intend to do regular 'X' in the next 6 months
Physical health	○	○	○	○	○	○

If you selected "I used to do 'X' regularly but have stopped in the last 6 months" why was this?

Having now attended the session, please consider your self-care support strategies for **mental health** once again.

e.g., You may wish to try mindfulness but haven't yet got around to it. Here you may wish to select *No, but I intend to do regular 'X' in the next 30 days.*

	Yes, I have been doing 'X' regularly for more than 6 months	Yes, I have been doing 'X' regularly, but for less than 6 months.	I used to do 'X' regularly but have stopped in the last 6 months.	No, but I intend to do regular 'X' in the next 30 days	No, but I have contemplated doing regular 'X' in the next 6 months	No, and I do not intend to do regular 'X' in the next 6 months
Mental health	○	○	○	○	○	○

If you selected "I used to do 'X' regularly but have stopped in the last 6 months" why was this?

Having now attended the session, please consider your self-care support strategies for **spiritual health** once again.

e.g., If you are already doing a regular activity that successfully supports your health, e.g. a prayer routine for spiritual health, you may wish to select *Yes, I have been doing 'X' regularly for more than 6 months*.

	Yes, I have been doing 'X' regularly for more than 6 months	Yes, I have been doing 'X' regularly, but for less than 6 months.	I used to do 'X' regularly but have stopped in the last 6 months.	No, but I intend to do regular 'X' in the next 30 days	No, but I have contemplated doing regular 'X' in the next 6 months	No, and I do not intend to do regular 'X' in the next 6 months
Spiritual health	○	○	○	○	○	○

If you selected "I used to do 'X' regularly but have stopped in the last 6 months" why was

this?

Having now attended the session, please consider your self-care support strategies for **social health** once again

e.g., You may not wish to try anything new, or indeed have time to do so. For example, you may know regular coffee dates with friends revitalise you, but at the moment you do not have the time or mental space to organise this. Here you may wish to select *No, and I do not intend to do regular 'X' in the next 6 months.*

	Yes, I have been doing 'X' regularly for more than 6 months	Yes, I have been doing 'X' regularly, but for less than 6 months.	I used to do 'X' regularly but have stopped in the last 6 months.	No, but I intend to do regular 'X' in the next 30 days	No, but I have contemplated doing regular 'X' in the next 6 months	No, and I do not intend to do regular 'X' in the next 6 months
Social health	○	○	○	○	○	○

If you selected "I used to do 'X' regularly but have stopped in the last 6 months" why was this?

Page 4: Your session experience

Please indicate how strongly you agree with the following statements.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I found the session engaging and enjoyable	○	○	○	○	○
It was clear what was expected of me during the session	○	○	○	○	○
The session prompted me to consider changes to my self-care practices	○	○	○	○	○
I feel the session had a good mix of activities	○	○	○	○	○
I feel the session discussed theology in an appropriate way	○	○	○	○	○
I found the session personally relevant	○	○	○	○	○

Please indicate how strongly you agree with the following statements.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
The session was the right length	○	○	○	○	○
The session suited my personal learning style	○	○	○	○	○
I found the teaching session with Jamie useful	○	○	○	○	○
I found the self-reflection session useful	○	○	○	○	○

I found the group work useful	○	○	○	○	○
I would attend this type of session again	○	○	○	○	○

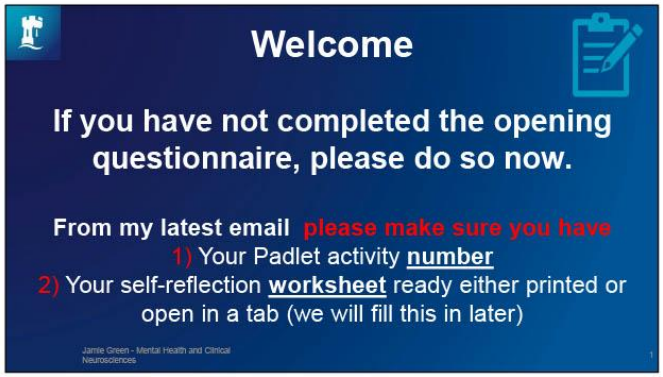
Please comment on your personal experience of the session, what you liked or disliked, what you would have liked to see more of, or any other suggestions for improvement. Please provide as much detail as possible.

Page 5: Success, your responses have been submitted.

Further support and information

If you would like further information or support on aspects of health and wellbeing, please contact the following agencies:

Appendix N – Intervention Education Section Slides With Notes



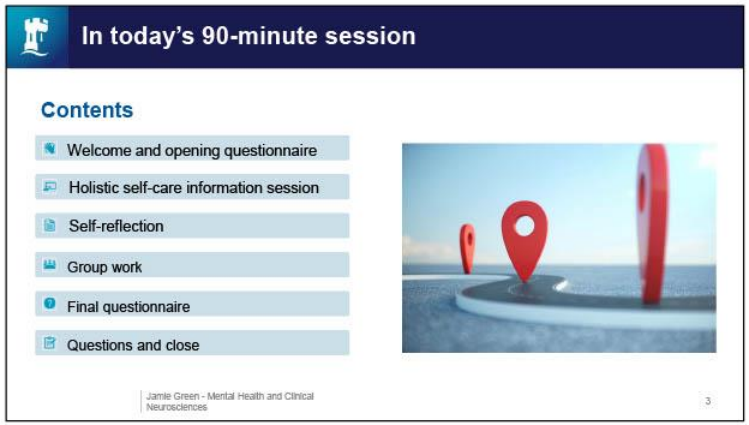
Opening questionnaire -
https://nottingham.onlinesurveys.ac.uk/clergy-health-and-wellbeing-pilot-intervention-2

1

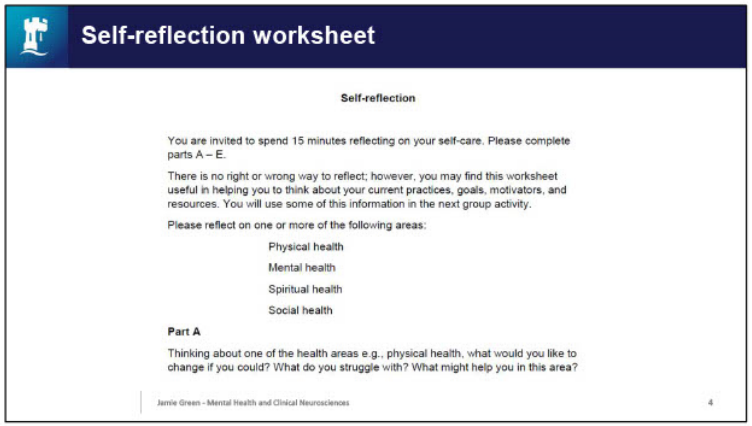
Slide Welcome everyone to this 90-minute holistic health and wellbeing session. My name is Jamie Green. I am a registered nurse, workplace health and wellbeing specialist and PhD researcher at the university of Nottingham. This session will form part of my final thesis, so your participation is greatly appreciated.

By saying yes or no in the chat, please can you let me know that you have completed the initial questionnaire.

2



Slide - Today's session will be broken down into 4 main sections, with space for questions at the end. Although this is a research study, there are no right or wrong answers, please answer honestly in all sections and participate as much as you feel comfortable and able. Full instructions will be given on each section.



https://static.onlinesurveys.ac.uk/media/account/171/survey/778455/question/Self-reflection_worksheet_V1_0_1hn126a.pdf

Slide - For the self-reflection section, you will need the worksheet emailed to you, in the instructions email, handy. The link to this is in the chat. Don't worry if you haven't printed this off, you can answer the questions / make notes using a separate pen and paper.

Opening prayer

Slide - So, let's begin with a prayer from Rob Campbell, Elder at New Life Baptist Church Northallerton.

Let's pray together. Lord we are so grateful that you model for us the ways in which you can live holistically, that when Jesus, you walked on this earth you took time out of the business of the schedule to look after your relationship with the father. That you took time for self-care in the midst of the pressures and the demands. And Lord we just ask that this time that would be spent together now would be really helpful in the business, in the stresses of ministerial life of shepherding folks. And we ask that you would bring to mind those things that you would identify as important for wellbeing in the months ahead. God may this be a fruitful time, and may you bring the holy spirit's presence and wisdom and guidance to the discussions that are about to be had. In your name Amen

Thank you to Rob.

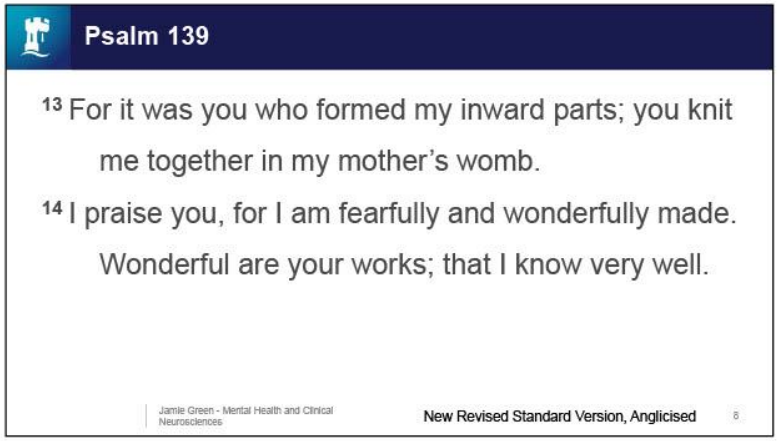
Information session

OK moving on to the information section:

Slide - I wasn't your average kid. Growing up I was fascinated with anatomy and physiology. Where other children favoured story books about princesses, I requested "The body book" a greys anatomy style manual as part of the family encyclopaedia (ahh the days before the internet).

I used to curl up on my dad's knee and he would read sections about veins and arteries, the heart, digestive system, muscles, and bones. Stopping periodically to check "Are you really enjoying this?!"

Being a physically fit fire fighter, I loved matching what we were reading to the visible musculature and circulation in dad's arms. Twisting his arms this way and that to see the blue veins or tendons flexing. My response then being much the same as it is now … the human body is AMAZING!



Slide - Psalm 139: 13&14 always resonates with me:

13 For it was you who formed my inward parts, you knit me together in my mother's womb.

14 I praise you, for I am fearfully and wonderfully made. Wonderful are your works, that I know very well.

God truly has given us, all of us, an immense gift. Yet so rarely (if at all as adults) do we stop to recognise

or marvel at it. We do however recognise when things go wrong.

Despite my fascination and wonder at our very form and functioning I, like so many of us, have suffered long, painful, and undignified periods of ill-health.

Slide - My love for health understandably directed me into a healthcare career as a nurse. However, It was here for a second time in my life that my body began to fail me. Working long shifts in intensive care my body began to physically resist. I developed chronic pain syndrome and a dangerous heart arrythmia.

Unable to work, Dr's in disagreement, depression setting in, medication only masking the pain not dealing with the underlying issues, I was at the end of myself.

Slide - This was all happening in my mid-twenties, a time when many are at their physical peak. Yet for me during this time on my worst days my husband would help with my basic care, the pain being so excruciating I could scream so loud the neighbours must have thought there was some grizzly murder taking place.

To put this into context I remember early on in my journey having a very real conversation with my care providers asking them If they amputated my left arm (my most painful part) would it make the pain stop.

I'd have rather lived as an amputee than go on like I was.

Notably the more in pain I was the harder I would pray. It's often works like that doesn't it? The bible is full of examples of emotional or physical pain fuelled prayers. Even our Lord and saviour in his final hours leaned on the father in prayer.

As my journey progressed the links between my different areas of health was becoming clearer. The greater the physical pain, the greater the emotional pain and the greater my spiritual health need.

During my recovery I worked with a specialist physiotherapist and acupuncture nurse. Between them they showed me that my mental health, and even my thought patterns could impact my physical wellbeing. Yes, my pain was a real physical reaction, but it could be helped by my own body's pain-relieving hormones. This was achieved not by doing anything grand but small movements and relaxing my mind.

You hear stories of martial arts grand masters achieving such mental control they can in effect switch off their pain receptors. Now I am in no way saying I reached that level, but I did begin to control my pain levels with my brain.

10

Slide - Believe it or not the small movements in cake decorating helped! OK and the eating bit too!

This was hard to comprehend at first as I had become so guarded of my painful areas (namely my left arm) that my muscles had atrophied, and my shoulder was no longer sitting in the socket as it should. But what I learned is, our minds are so complex they are like the supercomputer Apple wishes it could build. Just one of the brain's amazing functions is that when something breaks, either emotionally or physically, we have a function called neuroplasticity that enables us to 'grow' new neural pathways (brain connections) allowing us to overcome the most difficult of issues. Much like a stroke survivor relearns to speak, or an addict learns to resist the pull of a substance.

Contrary to old sayings, we **can** change, we **can** grow. I learnt I could overcome my pain through what I thought about it, how I carried myself, how I moved or guarded the areas that hurt most. This learning solidified the link for me between the mental and physical.

The NHS and the teams that work within are undoubtedly amazing, however health is often viewed with a rather myopic lens. This is how I was taught during my medical training. We zoom in so far on the presenting issue, that other factors such as our mental wellbeing are frequently not given the emphasis they should have or indeed they are overlooked entirely.

The more I researched during my recovery, the more the evidence pointed towards the detrimental effects of isolating any one health facet. We all have a physical health, a mental health, a spiritual health, a social health, an occupational health (and many other areas) all of which are **inextricably** linked.

11

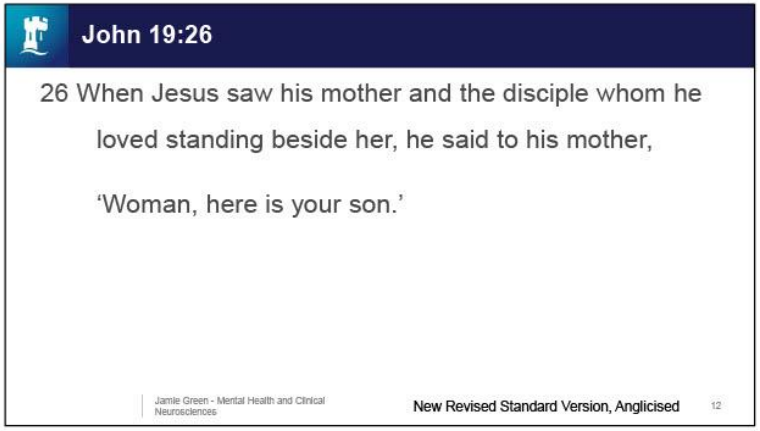
When one area is affected it affects one or more of the other facets like a biopsychosocial push and shove.

One linkage we have all felt over the past couple of years for example is between our social health (seeing friends and family in person) and our mental wellbeing. The additional pandemic for many, these past years, has been loneliness.

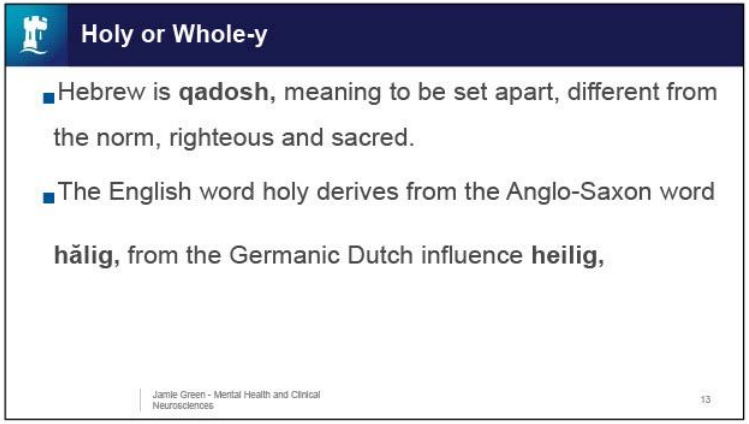
Yet in the west we are largely very poor at taking care of our health facets as a whole. We know generally how to care for some areas e.g. we should eat right, watch our alcohol intake, exercise etc. We also can notice the effects of activities, e.g., if we have faith, our spiritual health may be good, or it may be significantly impacted by the demands of our jobs. We are also becoming more aware of other areas such as our mental health. But often we are unsure of how to keep our minds healthy **before** there is a problem. Yet we haven't quite reached the point of considering our whole selves when we think about health and wellbeing.

Even Jesus highlighted the importance of the health facets throughout his life and ministry. He linked them healing people physically and suggesting a spiritual / mental/ emotional link (in the your sins are forgiven). Additionally, he didn't need to, but he travelled with 12 friends (his disciples) hinting at the importance of social support. He also fed people, on mass, as shown in the feeding of the 5,000 and 4,000. He healed people of various physical health issues throughout the gospels, he mourned with people (John 11:35, the shortest bible verse) and highlighted the importance of both emotional and practical support

11



Slide - John 19:26 with the disciple Jesus loved and Mary. He talked about sorrow, anxiety, joy, peace, love, anger the whole array of humanity. His ministry was not purely focussed on spiritual matters alone. Jesus died for the whole world and the **whole** of each human in it.



Slide - But if we have different facets to our health, what does it mean to be whole? The word holy is used in many world religions each with a slightly different view on its origin and meaning. The word holy in the original Hebrew is qadosh, meaning to be set apart, different from the norm, righteous and sacred. The English word holy derives from the Anglo-Saxon word hălig, from the Germanic Dutch influence heilig, in literal terms meaning well or whole. As humans encompass a mind, body and spirit which make us unique individuals, to be holy in Christian terms therefore, one must be indeed set

apart, righteous in spirit, but also whole and well in our person. This set-apartedness can too be arguably applied to holistic care of the body.

The legend that is the late Christian author Selwyn Hughes talks about self-care and care for the body when he writes.

Slide - *1 Corinthians 3:16-17 says - Don't you know that you are God's sanctuary and that the spirit of God lives in you?… God's sanctuary is holy, and that is what you are.*

Many centuries of misunderstanding have brought about a division between body and soul. This division is in evidence in some parts of the church today. Jesus, however, did not see His body as something to be ignored but something to be used. As He said, "You prepared a body for Me" (Heb 10:5). His body and soul were attuned. He neither neglected his body

nor pampered it, but offered it as the vehicle of God's will and purpose. And He kept it fit for God. There is no mention of His ever being sick. Tired yes, but never ill.

It is accepted today that body and soul are in unity, that a sick soul can produce a sick body, just as a healthy spirit contributes to a healthy body. It also works the other way around – a healthy body can contribute to good emotional and mental health. We Christians tend to overemphasise the spiritual side of life while underestimating the importance of physical facts like body chemistry, weather, water, air pollution, and nutrition. But through ignorance of the way in which body and soul are related, we succeed only in tearing them apart. I believe what is said about husband and wife in the marriage service can also be applied to the body and soul: "Therefore what God has joined together, man must not separate" (Mt 19:6).

Slide - *A good pianist may be able to get a lot out of a poor instrument, but he cannot give full expression to the music if the piano is out of tune. You cannot ignore the physical if you want to stay spiritually fresh. (Hughes, 2010, p. 1012)*

Got to love Selwyn! What a legend.

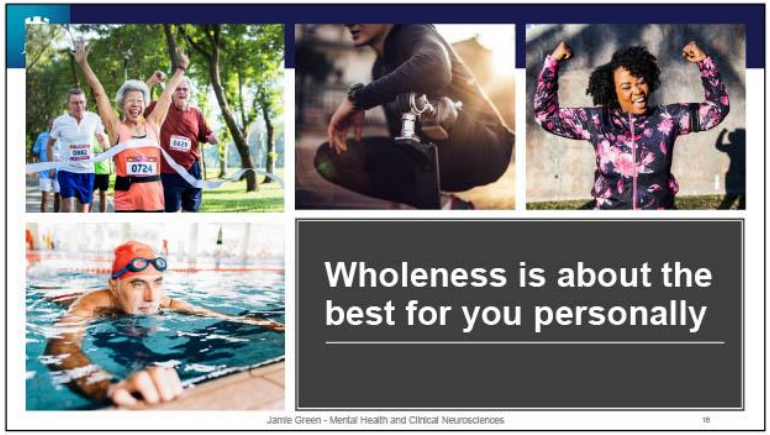
Paul's understanding of the linkage between body and spirit was such that he later in 1Corinthians 6:19 -20 highlights the matter again in the subsection *Glorify God in* ***Body*** *and spirit*.

19 Or do you know that your body is a temple of the

holy spirit within you, which you have from God and that you are not on your own? 20 For you were bought with a price; therefore glorify God in your body.

When someone comes round your house (most of us) do a little tidy up, spruce up the bathroom, layout fresh towels, make sure the milk is fresh etc. If we have the holy spirit living within us, should we too not give our physical selves a tidy up?

We know complications and diseases like hypertension, diabetes, stroke, several forms of cancer, high cholesterol, heart disease, dementia, many mental health issues, fertility issues, menopause issues (the list goes on) are **all** avoidable **yet** they are rife in the west! These issues destroy peoples lives and put a phenomenal strain on health services. Is it not part of our Christian duty (our set apart-ness) to take care of the gift of our health (in all its facets) **and** to be a living example to those around us?



Slide - Being healthy and whole does not mean becoming a gym bunny and striving for some unattainable version of mental or physical fitness. God didn't call us to be marine commandos. I know I'm certainly not. What he does want (as he does with our spiritual health) is a degree of responsibility, reflection, action, and living example).

In my story, my health and wellbeing requirements would at times look quite different to the average 30 something person. And I'm OK with it! I'm never going to be an athlete, as anyone who has seen me

attempt to run will attest! It's like I'm running frantically during the zombie apocalypse all limbs independent (or perhaps like the zombies themselves!) But despite my uncoordinated running and my underlying ill-ness I am moving towards being whole through careful consideration of what health means to me **personally, in all of its facets.**

Slide - I challenge you, to consider what health and wholeness mean to you. Are you there? Or do you need a little sprucing up to become a true temple for the holy spirit? Do you put one facet above the rest? Do you make excuses? Do you not set aside time, or is the time just not there and you need to ask for help? Sometimes the small sustainable changes are better than a host of big demanding ones. In the next activity we are going to examine our holistic self-care practices and focus on one or two small starting points for change or improvement.

https://static.onlinesurveys.ac.uk/media/account/171/survey/778455/question/Self-reflection_worksheet_V1_0_1hn126a.pdf

Slide - Self-reflection

Now having considered the idea of holistic self-care, we are going to spend 15 minutes thinking about aspects of our individual wellbeing. To do this we will be using the worksheet mentioned earlier.

I will set a timer for 15 minutes and give you a 5-minute warning before the end.

During this time, please consider any health and wellbeing challenges / issues that you would like to share with the group, we will be focussing on these in the next group work section. These issues can be from any area of health and wellbeing, mental, physical, social, spiritual etc.

You don't have to share anything you don't feel comfortable with.

OK if you have your worksheets ready, I'll start the 15-minute timer.

18

Wednesday - https://padlet.com/msxjg4/w7itcn7bifrynyto
Friday - https://padlet.com/msxjg4/dmom40e2bd863eqg
Latest - https://padlet.com/msxjg4/4vb5ygyuaxt3ys08

Slide - Group work

For this final 30- minute section, we will be looking at our individual health and wellbeing concerns more closely, spending around 5 minutes on each concern. The purpose of this section is support one another and share ideas, coping strategies, different vantage points to the concern, to help individuals begin to move towards healthy changes.

The issues will be posted anonymously using your number from the email I sent you. However, if you feel comfortable and able you may discuss your concern openly if you choose.

You do not have to share anything you do not feel comfortable with.

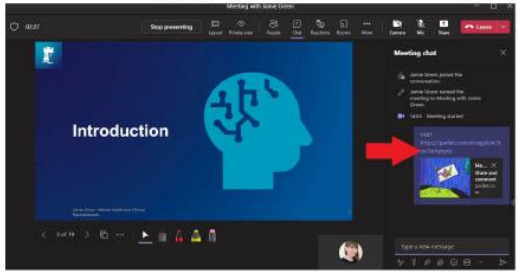
We will examine these concerns using the platform Padlet

*Padlet instructions

19

How to use Padlet

- Click on the link in the group chat

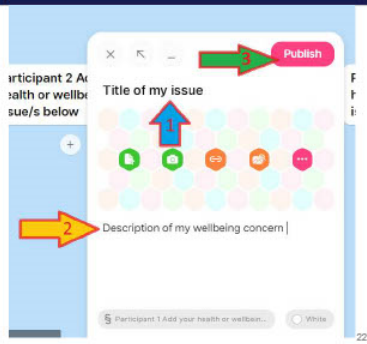


How to use Padlet

- Add you problem / concern under your corresponding number

How to use Padlet

- Press the '+' add a title and content then press publish in the top right hand corner

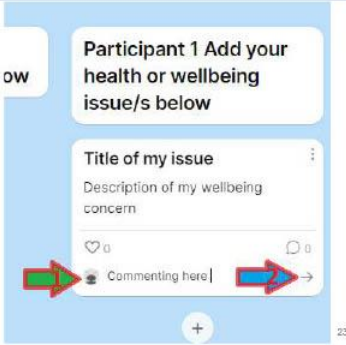


Jamie Green - Mental Health and Clinical Neurosciences

22

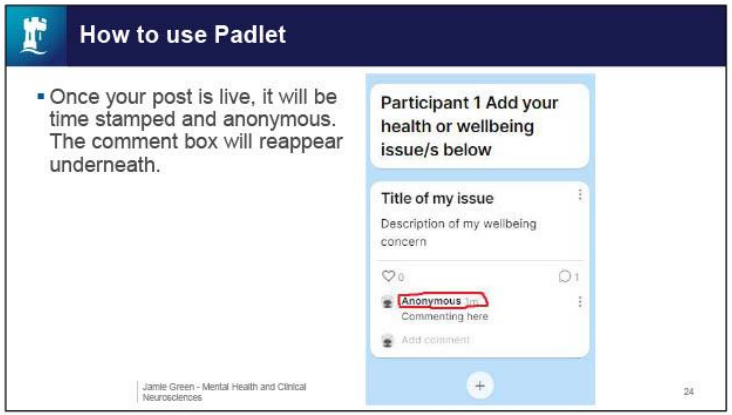
How to use Padlet

- Then start to comment on others issues using the 'comment' function. Click the arrow on the right hand side to post.



Jamie Green - Mental Health and Clinical Neurosciences

23



https://nottingham.onlinesurveys.ac.uk/clergy-health-and-wellbeing-pilot-intervention-part-2

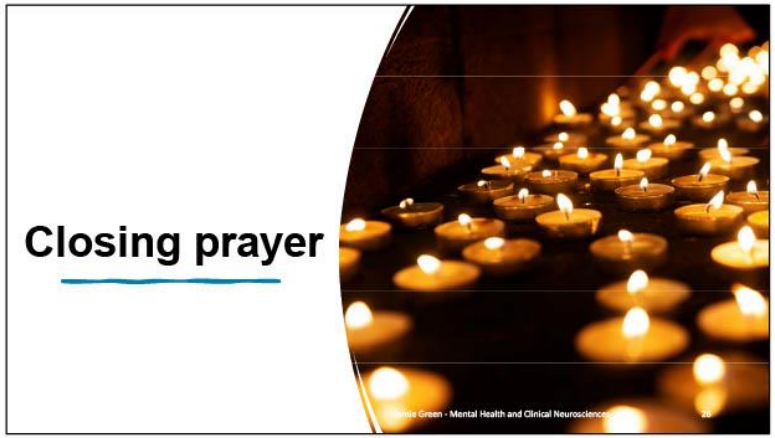
Slide - Final questionnaire

Having now completed the interactive parts of the session we are now going to spend the next 5 minutes completing the final questionnaire.

Please do not leave the session

When you have finished the questionnaire please type 'finished' in the chat.

The link to the questionnaire is in the chat now.



Slide - Closing prayer

Awesome father, thank you for each person here today. Thank you for their uniqueness, their individual bodies, minds, and spirituality. Thank you for the work they do in their churches and communities on a daily basis.

Father moving forward I ask that you equip each person with the skills, resources, support, and drive to protect and care for their holistic health. Each person here today has specific induvial health and wellbeing needs. Father I thank you that you know us inside and out, you know our weaknesses, when we make excuses, when we flag, and when we are at the end of ourselves. I pray moving forward that you will strengthen each of us in the areas we need, and that we will find the support and motivation necessary to make realistic sustainable changes. Father help us achieve our individual version of best holistic health.

I ask this in the name of Jesus amen.

26

Slide - Close

Once again everyone thankyou very much indeed for your participation today. I hope you have found the session enjoyable. If you have any questions after today, feel free to email me.

If no one has anything else I bring the session to a close.

Appendix O - Intervention Self-reflection Worksheet

Self-reflection

You are invited to spend 15 minutes reflecting on your self-care. Please complete parts A – E.

There is no right or wrong way to reflect; however, you may find this worksheet useful in helping you to think about your current practices, goals, motivators, and resources. You will use some of this information in the next group activity.

Please reflect on one or more of the following areas:

Physical health

Mental health

Spiritual health

Social health

Part A

Thinking about one of the health areas e.g., physical health, what would you like to change if you could? What do you struggle with? What might help you in this area?

Part B

Now you have identified an area for improvement, we are going to explore how you might change this area. This activity will encourage you to consider your 'capability', 'opportunity' and 'motivation'. Place an 'X' by the option/s which best apply to you, choose all that apply.

For example, if you would like to start exercising, you may circle in **capability** *'Have more physical stamina'*, *'Know more about how to do it'*, In **opportunity** *'Have more time to do it', 'Have more support from others'* and in **motivation** '*Feel that you want to do it enough',* and *'Develop a habit of doing it'*

Capability

Know more about why it was important	e.g. have a better understanding of the benefits of stopping smoking	

Know more about how to do it	e.g. have a better understanding of effective ways to loose weight	
Have better physical skills	e.g. learn how to operate machinery more effectively in one's job	
Have better mental skills	e.g. learn how reason more effectively	
Have more physical strength	e.g. build up muscles for demanding physical work	
Have more mental strength	e.g. develop stronger resilience against cravings	
Overcome physical limitations	e.g. get around problems of stature or disability	
Overcome mental obstacles	e.g. reduce unwanted urges or feelings	
Have more physical stamina	e.g. develop greater capacity to maintain physical effort	
Have more mental stamina	e.g. develop greater capacity to maintain mental effort	

Opportunity

Have more time to do it	e.g. create more dedicated time during the day	
Have more money	e.g. be given or earn funds to support the behaviour	
Have the necessary materials	e.g. acquire better tools for the job	
Have it more easily accessible	e.g. provide easier access to facilities	
Have more people around them doing it	e.g. be part of a 'crowd' who are doing it	
Have more triggers to prompt them	e.g. have more reminders at strategic times	
Have more support from others	e.g. have one's family or friends behind one	

Motivation

Feel that you want to do it enough	e.g. feel more of a sense of pleasure or satisfaction from doing it	
Feel that you need to do it enough	e.g. care more about negative consequences of not doing it	
Believe that it would be a good thing to do	e.g. have a stronger sense that one should do it	
Develop better plans for doing it	e.g. have clearer and better developed plans for achieving it	
Develop a habit of doing it	e.g. get into a pattern of doing it without having to think	
Something else (please specify)		

Part C

Now you have identified some of your needs and barriers, let explore your goal using the SMART acronym. E.g. For beginning exercise:

		Example
Your goal	*I would like to start exercising*	
S Specific	Define your goal, make it as detailed as possible.	*I would like to attend a local dance class twice a week. The classes cost £5 each and run from 7:30pm -8:30pm*
M Measurable	How do you know when you have reached your goal?	*As mentioned in the previous section I struggle with forming habits. I will know I have achieved my goal when I have attended classes for 6 months.*
A Achievable	Will you be able to achieve your goal, thinking about the cost in time, money, and other resources?	*I have budgeted for my classes by bringing coffee in a flask rather than buying Costa every day. I know I have the time, but I need to speak to my partner about emotional support. In the previous section I realised I need a little more support to keep going with new activities.*
R Realistic	Is your goal realistic given your current resources?	*I feel It is realistic on paper but given my level of fitness I am concerned I am going to tire easily and make excuses not to go back. I need to go at my own pace and have more encouragement from my partner.*
T Timely	Set a start date and an end date if applicable e.g., a weight loss goal for 6 – 9 months	Start __/__/____ End __/__/____ (Or ongoing) *I am going to start next week and set my 'end' as ongoing.*

Now try writing your own SMART goals for your chosen health area.

Your goal	*I would like to start exercising*	
S Specific	Define your goal, make it as detailed as possible.	
M Measurable	How do you know when you have reached your goal?	
A Achievable	Will you be able to achieve your goal, thinking about the cost in time, money, and other resources?	
R Realistic	Is your goal realistic given your current resources?	
T Timely	Set a start date and an end date if applicable e.g., a weight loss goal for 6 – 9 months	Start __/__/____ End __/__/____ (Or ongoing)

Part D

Are there any specific steps that would help you achieve your goal?

E.g., *Set some time aside to have an honest discussion with my partner about my exercise habits and what I need from them, and why it's important to me.*

Steps to take	When will you achieve this?

Part E

Next consider the **possible barriers** (we will look at the solutions section in the next group activity).

E.g., *Life gets in the way, I cave and don't make the effort to go out, my partner doesn't encourage me.*

Possible barriers to my goal	Possible actions that could help (we will look at solutions in the next group activity).

Appendix P – Ethics Approval Letters

Ethics Letter Study One - Health and Wellbeing of Baptist Church Clergy: A Descriptive Study

University of Nottingham
UK CHINA MALAYSIA

DPAP Committee

02/12/2019

Supervisor: Jonathan Houdmont

Applicant : Jamie Green

Project: Project Id Health & Wellbeing of Baptist and Nazarene Church Clergy: A Descriptive Study

A favourable opinion is given to the above named study on the understanding that the applicants conduct their research as described in the above numbered application. Applicants need to adhere to all conditions under which the ethical approval has been granted and use only materials and documentation that have been approved.
If it is proposed that if an approved project is subsequently subject to any significant change (for example to the date or place of data collection, or measures used), an Amendment Form should be submitted. This can be done in 'Create Sub Form' in the Actions Menu on the left hand side of the page on the on-line system: Select 'Amendment Form'.

yours

Professor David Daley

Co-Chair of DPAP Ethics Subcommittee

Professor Amanda Griffiths

Co-Chair of DPAP Ethics Subcommittee

Ethics Letter Study Two - Baptist Church Clergy Self-care: A Qualitative Investigation of Perceived Barriers and Facilitators.

DPAP Committee : 20/11/2020
Supervisor: Dr Jonathan Houdmont
Applicant: Jamie Green

Project ID : 1658
Project : Baptist and Nazarene Church Clergy Self-Care: A Qualitative Investigation of Perceived Barriers and Facilitators.

Dear Jamie,

A favourable opinion is given to the above named study on the understanding that the applicants conduct their research as described in the above numbered application. Applicants need to adhere to all conditions under which the ethical approval has been granted and use only materials and documentation that have been approved.

If you need to make any any changes (for example to the date or place of data collection, or measures used), an Amendment Form should be submitted. This can be done by the Supervisor in 'Create Sub Form' in the Actions Menu on the left hand side of the page on the on-line system: Select 'Amendment Form'

Yours

Professor David Daley

Co-Chair DPAP Ethics Subcommittee

Professor Amanda Griffiths

Co-Chair DPAP Ethics Subcommittee

Ethics Letter Study Four - Effectiveness, Acceptability, and Feasibility of An Intervention to Support Self-care in Baptist Church Clergy.

University of Nottingham
UK | CHINA | MALAYSIA

DPAP Committee: 10/06/2022
Supervisor: Dr Jonathan Houdmont
Applicant: Mrs Jamie Green
Project ID: 2849

Project Title: Effectiveness, acceptability, and feasibility of an intervention to support self-care in Baptist church clergy

Dear Jamie

A favourable opinion is given to the above-named study on the understanding that the applicants conduct their research as described in the above numbered application. Applicants need to adhere to all conditions under which the ethical approval has been granted and use only materials and documentation that have been approved.

If you need to make any changes (for example to the date or place of data collection, or measures used), an Amendment Form should be submitted. This can be done by the Supervisor in 'Create Sub Form' in the Actions Menu on the left-hand side of the page on the on-line system: Select 'Amendment Form'

Yours

Professor David Daley

Co-Chair DPAP Ethics Subcommittee

Professor Amanda Griffiths

Co-Chair DPAP Ethics Subcommittee

Ethics Letter Study Four Amendment – Extension of Study

University of Nottingham
UK CHINA MALAYSIA

DPAP Committee

16/08/2022

Supervisor:

Applicant : Jamie Green

Project: Project Id Effectiveness, acceptability, and feasibility of an intervention to support self-care in Baptist church clergy

The committee is pleased to confirm that the amendment relating to ref: DPAP - 2022 - 2849 - 1 has received approval. Please conduct your study following the amended procedures. If you need to make any further changes, please create a new amendement form.

yours sincerely

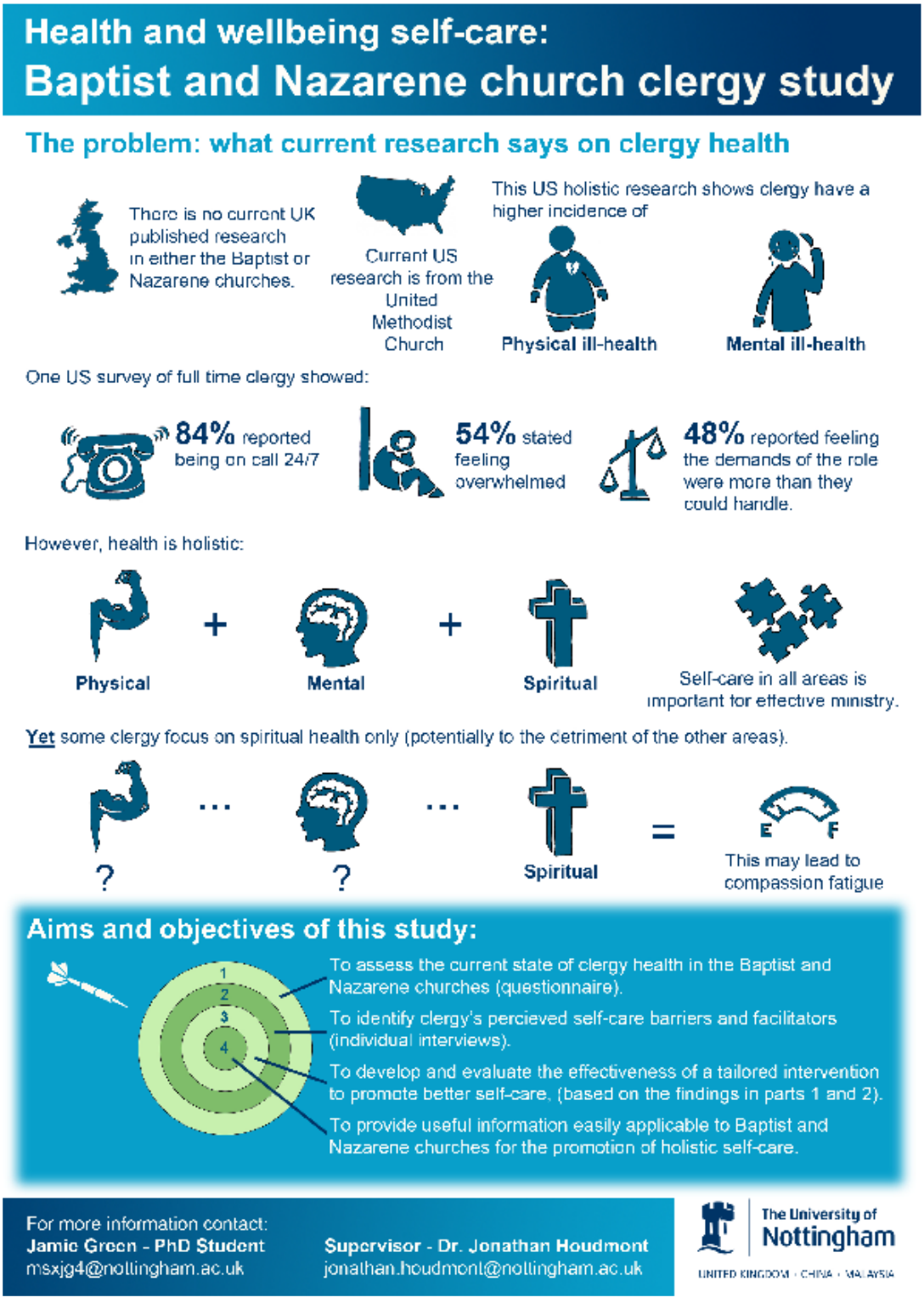
Dr Jen Yates

Chair of DoPAP Ethics Subcommittee

Appendix Q - Advertising Flyers for Each Study

All designed by Patrick Green (content and wording Jamie Green)

General Research Overview



Study One Flyer – Quantitative Phase

Study Two Flyer – Qualitative Phase

Ethics Number: 1658
Jamie Green - Student researcher
msxjg4@nottingham.ac.uk
Supervised by Dr Jonathan Houdmont -
http://www.nottingham.ac.uk/medicine/people/jonathan.houdmont

University of Nottingham
UK | CHINA | MALAYSIA

Study Four Flyer – Intervention

Baptist clergy health and wellbeing seminar

Could you improve your self-care?

There is a need to protect and promote health and wellbeing in clergy, yet this is a neglected area of research. In this study, we want to investigate the suitability of a tailored seminar to promote self-care practices.

We are looking for clergy to take part in a 90-minute online group seminar combining learning, self-reflection, and group activities.

The seminar will take place on (choose 1 date):
Wednesday 27th July 10:30 - 12:00
Friday 29th July 13:00 - 14:30

For more details and to sign up please contact jamie.green@nottingham.ac.uk

Jamie Green – Doctoral candidate
Jamie.green@nottingham.ac.uk
Ethical approval has been granted by the ethics committee of the School of Medicine, University of Nottingham.
Ethics reference number 2849

University of Nottingham
UK | CHINA | MALAYSIA

Study Four Flyer – Intervention After Extension

Baptist clergy health and wellbeing seminar

Could you improve your self-care?

There is a need to protect and promote health and wellbeing in clergy, yet this is a neglected area of research. In this study, we want to investigate the suitability of a tailored seminar to promote self-care practices.

We are looking for clergy to take part in a 90-minute online group seminar combining learning, self-reflection, and group activities.

New dates added

The seminar will take place on (choose 1 date):
Wednesday 14th September 10:30 - 12:00
Friday 16th September 13:00 - 14:30
Wednesday 21st September 13:00 - 14:30
Friday 23rd September 10:30 - 12:00

For more details and to sign up please contact jamie.green@nottingham.ac.uk

Jamie Green – Doctoral candidate
Jamie.green@nottingham.ac.uk
Ethical approval has been granted by the ethics committee of the School of Medicine, University of Nottingham.
Ethics reference number 2849

University of Nottingham
UK | CHINA | MALAYSIA

Appendix R

Poster Presented at American Psychological Association Annual Work Stress and Health Conference, Philadelphia, PA, United States.

University of Nottingham
UK | CHINA | MALAYSIA

Baptist and Nazarene Church Clergy Health and Wellbeing Self-Care: A mixed methods study

Mrs Jamie I Green[1], Dr Jonathan Houdmont[2], Dr Louise Thomson[2]

Background

Christian church leadership is a unique **multi-faceted occupation** with leaders performing many roles such as public speaker, counsellor, and company director. These vocational demands and devotion to church activities may negatively affect leaders' holistic health (physical, mental, and spiritual). What appears evident from North American literature is that the holistic health of clergy, despite some religious coping strategies, falls short relative to comparative adult populations. A survey of 1,500 United Methodist Church ministers found that **84% reported being on call 24/7**, 54% stated feeling overwhelmed, and 48% reported feeling the demands of the role were more than they could handle.

Recent US research indicates that both new and established clergy welcome the notion of workplace health and wellbeing initiatives to protect and promote their holistic health. However, published research on the holistic health status, beliefs and behavior of ministers globally, is sparse. Beyond the US, few attempts have been made to examine holistic health with respect to occupation-specific and theologically influenced behaviours. **To date, no UK holistic health research** has been conducted in the Baptist and Nazarene Churches.

References

Cowper, G. L. (2012). *An analysis of the relationship between physical exercise and the spiritual life of clergy*. Unpublished doctoral dissertation, Gordon-Conwell Theological Seminary.

Elders, K. L. (2010). *A fitness model for pastors*. Unpublished doctoral dissertation, Liberty Baptist Theological Seminary.

Jenkins, G. (2018). *Clergy supportive spiritual practices*. Unpublished doctoral dissertation, Wilfrid Laurier University.

Lifeway Research (2015). Pastor protection research study: Survey of 1,500 American pastors. Retrieved from http://lifewayresearch.com/wp-content/uploads/2015/08/Pastor-Protection-Quantitative-Report-Final.pdf

Morrow, B. J. (2018). *Pastoral well-being & beyond: Three streams of pastoral health and personal development*. Unpublished doctoral dissertation, George Fox University.

Prochaska, J. O., & DiClemente, C. C. (2005). The transtheoretical approach. In J. C. Norcross, & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 147-171). Oxford: Oxford University Press.

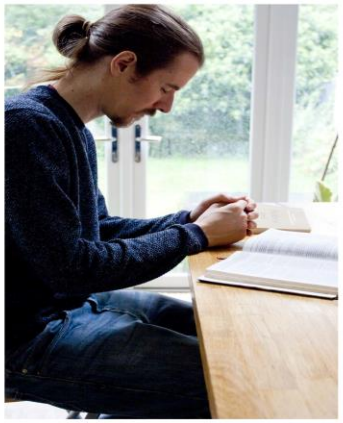
Proeschold-Bell, R. J., & LeGrand, S. (2010). High rates of obesity and chronic disease amongst United Methodist clergy. *Obesity*, 18, 1867-1870. https://doi.org/doi:10.1038/oby.2010.102

Rowell, J. L. (2010). *Clergy retention in the Church of the Nazarene, the role of the district superintendent in clergy decision-making regarding persistence in active vocational ministry*. Unpublished doctoral dissertation, Olivet Nazarene University.

WesPath Benefits / Investments (2017). *Well-being survey of the United Methodist church active U.S. clergy—2017*. Retrieved from https://www.wespath.org/assets/1/7/5058.pdf

Aims

The objective of this investigation is to **profile and identify barriers and facilitators of holistic health self-care beliefs and practices** of UK Christian Church leaders in the Baptist and Nazarene churches.



- This health profile will highlight areas for development within this occupational group
- The research will provide an evidence base concerning clergy's perceived barriers and facilitators to self-care.
- Additionally, this research aims to demonstrate that through a modest tailored intervention, holistic health may be promoted via improved self-care methods.

Methods

Participants - The **Baptist church, being the fifth largest Christian church in the world**, has approximately four thousand churches in the UK. **The Church of the Nazarene has 90 UK churches** with a global reach of 2.5 million members. These denominations share **commonalities** in doctrine, church activities, and worship practices. They differ, however, in terms of their churches' financial and operational structures, with implications for variance in clergy job roles, security, and salary. Whether these **differences** are associated with health and wellbeing outcomes remains an empirical question.

Study one comprises an online quantitative survey to examine **current clergy self-care beliefs and behaviours**.

Study two is a qualitative **interview-based study** that will examine perceived facilitators and barriers to self-care.

Pilot Intervention - The findings of studies of one and two will inform the design of a **bespoke role-specific theologically- and theoretically-based intervention** to promote self-care. The intervention's effectiveness will be examined in a quantitative survey pre–intervention with 3- and 6-month post intervention assessments. This approach will enable the effectiveness of the intervention to be assessed through the lens of the **transtheoretical model of behaviour change**.

1 - PhD Student - Division of Psychiatry and Applied Psychology, Faculty of Medicine & Health Sciences, University of Nottingham
2 - Assistant Professor of Occupational Health Psychology, Faculty of Medicine & Health Sciences, University of Nottingham

Design Patrick Green (content and wording Jamie Green)

Poster Presented at the School of Medicine Research Impact Forum, The University of Nottingham, Virtual Event.