



Clergy  
Wellness  
Report

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**Beloved, I pray that all may go well with you  
and that you may be in good health,  
just as it is well with your soul.**

– III John 2

CREDO

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**Episcopal Clergy Wellness:  
A Report to The Church on the State of Clergy Wellness  
June 2006**

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## Introduction

For bishops, priests, and deacons to lead – to be “wholesome examples” to the people of God – their own wellness must be cared for and cultivated. This report focuses on the wellness of clergy with a particular emphasis on ordained servant leaders – bishops, priests, and deacons. But its ultimate concern is for the vitality of the whole Church.

The Episcopal Clergy Wellness Report seeks to provide a long-term, systemic, and strategic perspective to strengthen clergy – and ultimately the Church – through a focus on wellness. The report presents a current “snapshot” of the state of wellness in a sample of Episcopal clergy through an analysis of key indicators of health and well-being. However, this snapshot should be seen as a moving picture – a slice in time of a dynamic and fluid process of “becoming,” a willingness to engage in a lifetime of change toward increased wellness.

This report is intended to serve as a benchmark for future reports, to be produced every six years, to discover trends and suggest potential courses of action to improve overall clergy wellness. By extension, healthy and well clergy will have broader systemic effects on the wellness of parishes and dioceses, and thus the Church as a whole.

The Episcopal Clergy Wellness Report is a framework to increase understanding of the current state of wellness among clergy, as well as to provide the Church and its leaders with accurate, timely, and relevant information. The report seeks to capitalize upon knowledge of clergy health and well-being gathered by CREDO Institute, Inc. and to leverage it to the broader use of the Church. Most importantly, it is hoped that this report will serve as both a catalyst and means to:

- (1) Marshal resources for the continuous improvement of clergy wellness.
- (2) Foster an attitude toward wellness that dwells not on the pathological but the positive.
- (3) Guide the Church into new understandings of wellness and its antecedents and consequences.
- (4) Signal a new awareness about wellness that will permeate Church culture.
- (5) Celebrate victories and successes.

*The Episcopal Clergy Wellness Report seeks to provide a long-term, systemic, and strategic perspective to strengthen clergy and ultimately the Church through a focus on wellness.*

## Context

The responsibility to manage our health must not be viewed as a selfish pursuit. Our wellness extends its benefits beyond self-interest and into our relationships: social groups, families, organizations, and society as a whole.

Over the past two decades, many types of organizations have awakened to the holistic nature of their leaders and members. For example, the notion that people come to work as whole beings (with physical, mental, emotional, and spiritual needs for expression and growth) is currently evolving as a new perspective of management studies known as “workplace spirituality” (e.g., Giacalone & Jurkiewicz, 2003; Sheep, in press, 2006). The development and wellness of “whole individuals” has thus increasingly become the concern of those who provide vision for and lead organizations.

In recent studies, employee health and well-being have been linked significantly to reduced absenteeism and turnover, as well as increased conscientiousness and productivity (Cooper & Cartwright, 1994). As a result, opportunities for wellness at work (e.g., employee health and retirement benefits, fitness and daycare centers, prevention and recovery programs) have never been more important in organizational planning.

However, even amid this corporate awakening, there have been rising threats to wellness. Rapid changes in the “brave new world” of work – marked by more turbulent operating environments for organizations and more fluid career paths for members – have increased the levels of stress and ambiguity for those caught in the cross hairs of change. Due to restructuring, increased competition, and consequent mandates for efficiency and effectiveness, greater expectations are placed on the individual to pull off superior or even super-human performance at work – somehow balanced with a satisfying home life and social relationships.

As much as we would like to think of the Church as a place of refuge and healing from this temporal storm, its servant leaders have been swept up by these and other organizational and cultural changes. Thus, it is the overarching goal of the Episcopal Clergy Wellness Report to provide specific reasons for hope and a way forward for clergy to maximize the benefits of personal wellness to themselves and to the Church in such times of change and promise.

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## Toward a Theology of Wellness

*Beloved, I pray that all may go well with you  
and that you may be in good health,  
just as it is well with your soul. III John 2*

*"Be perfect, just as  
your heavenly  
Father is perfect."  
Matthew 5:48*

### Rooted in the Reign of God

The concept of wellness lies very close to the heart of the gospel. Jesus said he came so that we might have abundant life. He tells his friends that they must be whole, wholesome, completed, just as God is: "Be perfect, just as your heavenly Father is perfect." (Matthew 5:48) The Greek word we translate as perfect is *teleios*, which means to be brought to completion, to maturity, to wholeness. Perhaps the most significant sign of Jesus' identity and his inauguration of the Reign of God was his ministry of healing. Story after story in the gospels tell us about Jesus' compassion for those who were sick or suffering. When the disciples of John ask Jesus if he is the one they have been waiting for, he tells them to go and tell John what they have seen: Because of Jesus, the blind see, the lame walk, and the poor finally hear good news. Even the forgiveness of sin is presented in terms of healing and restoration to a state of wellness. The woman caught in the act of adultery is set free from the judgment of her accusers and told to go and sin no more. Jesus restores the integrity of her personhood. He makes her well.

The early Church continued to make sense of its experience of the Risen Christ in terms of health and wellness. Immediately after the experience of Pentecost, Peter and John encounter a man lame from birth and tell him all they have to give him is healing in the name of Jesus. The man walks. We might think of Paul's image of the Body of Christ, various parts working together with ease and suppleness so that the whole body might move and grow into maturity. When one member is unhealthy or diseased, says Paul, the whole body suffers. Life in Christ is growth into the image and likeness of Christ who is the perfect image of God. The startling claim of scripture is that the fullness of deity dwells bodily in Christ and that we come to that same fullness of life because we are members of Christ (Col. 2:9-10). To be in union with Christ is to be made well in an ultimate sense.

### Balance and Holy Relationship

Physicians describe a healthy body as one in which physical systems are in balance, working together with ease so that a person is able to meet the challenges of growth and change and able to engage in life-giving relationships. Similarly, for members of the Body of Christ, the image of the Holy Trinity itself illustrates the importance of what we mean by wellness. Think of Rublev's great icon of the Holy Trinity. In it the three angelic visitors to Abraham and Sarah are seated at a table, lovingly inclined toward one another. They are peacefully attentive to each other, distinct persons in a dynamic communion of love, engaged in a holy communion that is not closed in upon itself, but radically



open. The holy conversation at that table creates a space for the viewer, for us. We are invited into a transforming relationship with God and one another. Ultimately we call this eternal life.

Wellness, wholeness, abundant life is the will of God for all God's people. The Baptismal Covenant commits all the members of the Church to practices that support and sustain the health of the Body of Christ. "Will you do all in your power to uphold these persons in their life in Christ?" we ask. Respect for the integrity, the dignity of every human person is central to the baptismal promises. The Eucharistic assembly is a model of differentiated unity – all the members of the Church take distinctive roles in the celebration, and all are needed so that the meal may be shared, the Body nourished and empowered for mission. The Church has taken important steps to ensure that all its members can live in safety. Intentional ministries of health and wholeness have arisen in many places. For physicians, nurses, and healthcare professionals there is an increasing interest in the importance of spirituality and the life of prayer in achieving and sustaining health. Prayer groups and ministers of healing are rediscovering the riches of our tradition in the laying on of hands and anointing. There is a growing recognition that genuine health depends on the interdependence and integration of mind, body and spirit, and that promoting this integration is the business of the whole Church.

## Resiliency and Diversity

The Church is an outward and visible sign of the mystery of Christ. The strength of any sacramental sign depends on its capacity to signify the reality to which it points, to provide access to the reality in which it participates. Healthy and well-differentiated relationships within the Church signify the dynamic love of God in Christ which makes itself vulnerable to the wounds of the world. Healthy relationships – with others and with the self – make for a resiliency which is capable of meeting, embracing, and transforming pain and confusion, no small matter in a world of rapid change and chronic anxiety. Again, the human body provides an analogy. As the writer David Whyte points out, a healthy heartbeat is constantly changing, responding to stimuli, while the sure sign of a heart about to die is a dull, unwavering beat. Over time, a healthy heart, constantly subject to fluctuations and changes in rhythm, demonstrates a remarkably stable pattern. In a healthy body, organs and systems exist in complementary relationships capable of adapting and responding to challenges and change.

## Healthy Holy Order

God does indeed give a variety of gifts and all for the common good. When leadership is healthy it provides the means for diverse gifts to be offered and put to effective use. Strong, loving, and wise leaders are necessary for the mission of the Church. The wisdom of the monastic tradition reminds us that a healthy community depends on a rich diversity of relationships and that those relationships must be freely disciplined. The Rule of St. Benedict insists that this is a matter of deep obedience to Christ, the transformation of the will and the heart in the love of God. The community is ordered not for its own sake, but so that the gifts of all may be identified, cherished, and put to good use. Ordained ministry, Holy Order, exists in the Church to assure an environment in which diversity may flourish for the sake of the resiliency, the vitality of the whole body.

*The Baptismal Covenant commits all the members of the Church to practices that support and sustain the health of the Body of Christ. "Will you do all in your power to uphold these persons in their life in Christ?" we ask.*



## Most Significant Findings

In March 2006, a panel of 14 Church leaders met in Memphis, Tennessee, to review the findings of the research and comment on the most interesting and relevant findings. The following summarizes these findings, to be discussed more fully in the body of the Wellness Report, based on the panel's perspectives and suggestions.

### Critical Health Risk Factors

Health data on the sample of Episcopal clergy compiled by the Mayo Clinic cover a wide range of health assessments, including psychological and physical indices. Respondents report existing medical conditions and lifestyle behaviors that are summarized in a personal risk-assessment profile. Data from the Episcopal clergy sample of 646 respondents were compared to a much larger "benchmark" sample of individuals from all organizations that use the Mayo Clinic Health Risk Assessment (HRA) online service. An analysis of the aggregate data identifies striking percentage differences between the two groups in key health risk areas:

#### ♦ Warning signals in key medical conditions

High cholesterol, high blood pressure, and allergies topped the list of medical conditions reported by Episcopal clergy. More than 24% were at risk for high cholesterol, and 20.7% were at risk for high blood pressure.

#### ♦ More stress reported

The only major lifestyle factor for which Episcopal clergy were at greater risk than the larger population was stress, posing an emotional health risk for 72.9% of the Episcopal clergy sample (16.7% higher for males and 13.3% higher for females than the benchmark for each gender).

#### ♦ Significant prevalence of depression

Depression was the medical condition for which Episcopal clergy exceeded the benchmark population by the highest percentage difference (12.4%) and was reported more often by females (27%) than males (15%).

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## Wellness Markers for Greater Effectiveness in Ordained Ministry

Although the Episcopal clergy have reported many serious health risk factors, their general sense of well-being, confidence in undertaking new challenges, and commitment to their ministries are strong. The sampled clergy completed a Longitudinal Research Survey (LRS) to gather aggregate data on attitudes and beliefs based on measures derived from the social science, religious, and medical literatures.

- ♦ **General self-efficacy** is defined as confidence in one's ability to undertake a challenge and succeed. Eighty-six percent of Episcopal clergy reported moderate to high range in their confidence to undertake challenges and engage effectively in their ministries.
- ♦ **Meaningfulness in work** is a positive indicator for well-being and other beneficial variables, including work-life balance, organizational identification, and all types of specific self-efficacies. Nearly a third of the clergy sample reported a perfect score of 7, indicating that they experienced the highest level of meaningfulness in their work.
- ♦ **Well-being variables** were reported at moderate to high levels in the following categories: 92% in religious well-being, 90% in existential well-being, and 79% in career/vocation satisfaction.
- ♦ **Turnover intent** is a behavioral indicator of increased levels of stress and other factors. Lower turnover intent for the clergy was strongly associated with higher levels of well-being, all types of self-efficacy, meaningfulness in work, work-life balance, and readiness for development. Although Episcopal clergy reported higher levels of stress than the general population, their levels also were high in all of the above variables that lower turnover intent.
- ♦ **Emotional labor** requires people to suppress or simulate their emotions. It is a significant predictor of higher turnover intent. The good news is that most Episcopal clergy experienced neither extreme of emotional labor (most scored at medium levels with only 14% at higher levels). Thus, both emotional labor and turnover intent (at 7.7%) were relatively low for the Episcopal clergy sample.

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## Readiness to Change

The most certain sign of wellness in its broadest sense may be the measure of willingness to change. It addresses not only past and current conditions but shows how one is progressing toward the future with strong hope that desired outcomes can be achieved. Three broad measures in the data – “drivers for change” – signaled a high level of readiness and confidence on the part of clergy to take positive action related to their wellness. Most notably:

*The good news is that 81% of clergy have moderate to high levels of readiness for development, and only 7.7% indicate an intent to leave the practice of ordained ministry.*

♦ **Episcopal clergy are more “action-oriented” in their readiness to change** their emotional health, exercise and nutrition habits, tobacco use, and weight, compared to a much larger benchmark sample from other organizations. Episcopal clergy were in the “action” stage of readiness to change for seven Mayo Clinic health risk behaviors (as opposed to merely contemplating those changes) at a rate that was, on average, 9.5% higher than the larger benchmark population.

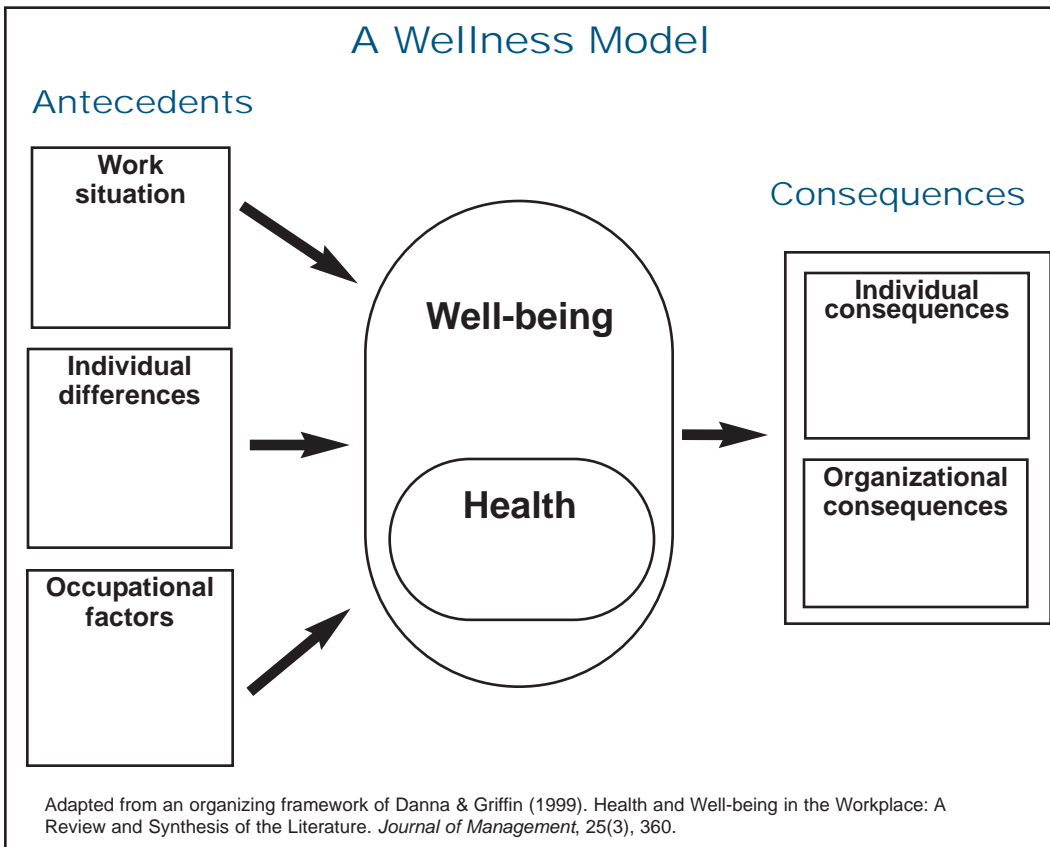
This forecasts good things to come in future assessments of the Health Risk Data. The Mayo Clinic frames the greatest health “risk factors” as a positive, forward-looking wellness agenda for individuals as well as for organizations. Thus, rather than dwelling on the understandable concerns of high risk factors, Mayo highlights them as “priority areas for you to consider as your greatest opportunities for impact.”

♦ **The well-being of Episcopal clergy is strongly related to their readiness for development.** This is also a strong indicator of lower intent to leave the practice of ordained ministry (turnover). The good news is that 81% of clergy have moderate to high levels of readiness for development, and only 7.7% indicate an intent to leave the practice of ordained ministry.

♦ **Various types of self-efficacy – that is, confidence in one’s ability for successful action – also are at relatively high levels in Episcopal clergy.** Moreover, if an individual has a high level of one type of self-efficacy (general, financial, physical, vocational, spiritual, and support), then he or she is likely to be at high levels for all other types as well. This is important because self-efficacy is highly related to all types of well-being.

## Factors Impacting Wellness

The concepts and perceptions of wellness are influenced by a broad array of contributing factors as illustrated in the model below. This wellness model provides a useful framework for identifying and understanding the antecedents, nature, and consequences of individual wellness. Specific issues centered on work-home boundaries, demographic/self-efficacy differences, and occupational factors that impact one's wellness health, as well as related attitudes and behaviors. This model clearly depicts the dynamic relationships of many contributing factors and will be discussed in more detail later in this report.



*Health has been defined by the World Health Organization (1998) as a "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."*

## Recommendations to the Church

As described earlier in the report, the panel of Church leaders who gathered in Memphis in March 2006 not only identified important “zingers” in the study’s findings, but they also produced a list of recommendations for future action to develop and grow efforts that would increase levels of Episcopal clergy wellness.

The recommendations listed below are broad and systemic in nature calling for collaboration of key organizations and institutions in the Church. The Rev. James C. Fenhagen, in his book, *Ministry for a New Time*, defines systemic change as “change that involves an ongoing willingness to examine the way we live as ‘members one of another’ to identify the points of connection that contribute to the strength and well-being of both the church as an institution and those who share in its life.”

By working with a collaborative spirit, Episcopal entities have the capacity and resolve to advance leadership and wellness programs. Such partnerships can make a positive impact on the life of clergy, congregations, dioceses, and the Church.

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### Consultation

- ♦ Plan and implement a Wellness Summit Conference within the 24 months after General Convention with collaboration of other Episcopal organizations.

### Resources and Programs

- ♦ Develop a process whereby seminarians could establish a “wellness baseline” in domains of personal stewardship: vocational, spiritual, physical, emotional, educational, financial, and recreational.
- ♦ Develop processes and resources for discernment, assessment and evaluation – a wellness composite – for multiple levels, including parishes, dioceses, provinces and the national Church.
- ♦ Develop an online Episcopal “Wellness Hub,” complete with links, self-assessments, and resources.
- ♦ Develop a best practices guide for dioceses regarding wellness. Best practices could be shared among dioceses.
- ♦ Develop or find an accessible system of life coaching.
- ♦ Create a confidential “depression and stress hot line,” a safe place to access resources.

## Research Topics

- ♦ Research the emotional health (stress, depression, and other mental health issues) of clergy. What are the causal factors? Are clergy being treated? How are they treated and are sufficient treatment resources available? Does it make a difference? What are the strategies to alleviate stress and depression in clergy? How could we do a wellness screening (as opposed to a depression screening)? What is our ability to make systemic extrapolations from the data, i.e. if clergy are stressed or depressed, how does that impact the whole Church system?
- ♦ Conduct a new study on the economic issues facing clergy – debt load of seminarians, credit card debt of clergy, housing issues (especially given the high price of housing in a number of markets), rectories versus owning.
- ♦ Conduct a comprehensive study on ordained women (deacons, priests, and bishops); this research would include career patterns, vocational satisfaction, turnover intent, and compensation; to correlate with the 30th anniversary in 2007.
- ♦ Conduct a comprehensive study on clergy of color (deacons, priests, and bishops); this research would include career patterns, vocational satisfaction, turnover intent, and compensation.
- ♦ Conduct research on the dynamics and forces impacting clergy families; identify key areas of wellness and ways the Church might employ sustainable and strategic resources to address clergy family issues.

Your participation is invited.  
*Your ideas and suggestions would be welcomed and valued. Please add to this list by e-mailing your suggestions to:*  
*credo@episcopalcredo.org*

*What is our ability to make systemic extrapolations from the data – if clergy are stressed or depressed, how does that impact the whole Church system?*

# The Episcopal Clergy Wellness Report

## History and Background

The Episcopal Clergy Wellness Report was developed from data gathered by CREDO Institute, Inc. from clergy participants in CREDO conferences. CREDO Institute is a not-for-profit corporation, incorporated by the Church Pension Fund in Delaware with headquarters in Memphis, Tennessee. This organization provides the CREDO benefit to plan participants of the Church Pension Fund.

CREDO conferences are for clergy to explore holistic wellness through a focus on four components – health, vocational, financial, and spiritual – both individually and in community. The mission of the eight-day conference is “to provide opportunities for clergy to examine significant areas of their lives and to discern prayerfully the future direction of their vocation as they respond to God’s call in a life-long process of practice and transformation.”

Since its pilot phase, CREDO has included longitudinal, scientific research designed by social scientist consultants as an integrated program component. As a result of this commitment to research, now nine years after the first conference, it is possible to monitor and document statistically and confidently the current state of clergy wellness in many dimensions. As of June 2006, 2,529 clergy, including 86 bishops, have attended a CREDO conference.

In preparation for CREDO conferences, participants are asked to complete pre-conference materials and assessments. This report focuses on highlights from the ongoing analysis of a subset of the data from the more than 500 clergy who attended CREDO conferences in 2005.

## Method

### Sample

The sample for this report is drawn from the overall population of Episcopal clergy who were randomly selected for invitation to attend a CREDO conference in 2005. All of those in the sample (more than 500 clergy) accepted the invitation to attend and complete pre-conference questionnaires that provide the data for this report.

### Sources of Data

Data for this report were drawn from three primary sources, all completed by CREDO participants in their preparation for attending a CREDO conference. The three sources of data are: the Longitudinal Research Survey (LRS); a financial practices questionnaire; and the Mayo Clinic Health Risk Assessment (HRA). It is important to note that the confidentiality of individual participants’ responses is maintained throughout the research process. Data reported are compiled summaries so that confidentiality is ensured. A brief description of each of these instruments follows.

*CREDO Institute,  
Inc. mission  
statement:  
To serve as a collaborative  
alliance  
providing resources  
for Episcopal  
leadership and  
wellness programs.*



**The Mayo Clinic Health Risk Assessment (HRA)** is administered through the Mayo Clinic website and includes a wide range of health assessments, including psychological (e.g., stress and depression, stages of readiness to change) and physical (e.g., cholesterol, blood pressure, triglycerides, weight, blood sugar) indices. Respondents also report existing medical conditions, such as allergies and diabetes, and current dietary and exercise practices. Respondents are provided with a risk-assessment profile, including any existing medical risk factors that could impact their current or future wellness. The Mayo Clinic HRA provides reports to CREDO Institute, including summaries of clergy lifestyle and medical risk factors, reported medical conditions, and stages of readiness to change behaviors that may pose health risks.

**The Longitudinal Research Survey (LRS)** is a multiple-measure survey designed to evaluate attitudes and beliefs of participants. Although the LRS is administered both pre- and post-conference to ascertain changes in attitudes and beliefs as a result of the CREDO conference, only data from the pre-conference surveys are included in this report. Thus, the data set includes responses from the sampled group of clergy prior to any wellness intervention. The measures included in the LRS were derived from the social science, religious, and medical literatures or were developed for CREDO. The survey includes 135 items comprising 18 different measures or indices of well-being, including vocational satisfaction, specific and general self-efficacy, turnover intention, emotional labor, meaningfulness of work, organizational identification, safety, availability, work-life balance, readiness for development, spiritual well-being, and adult APGAR, as well as sub-indices within many of these measures. More information on the content of these measures is available in the glossary (see Appendix 2).

**The Financial Practices Questionnaire** asks participants to respond “yes” or “no” to a checklist of items about the current state of their financial affairs. Items include: “I know what my financial situation would be in the event of change;” “I have completed a net worth statement;” “I understand my retirement benefits;” “I have an up-to-date will;” and other items. The financial practices questionnaire is administered online through a secured website to ensure the confidentiality of survey respondents. The demographic data obtained through the financial practices questionnaire, as well as the aggregated responses to questionnaire items, are included throughout this report.

## Report Demographics

The primary demographic findings are presented on the following two pages.

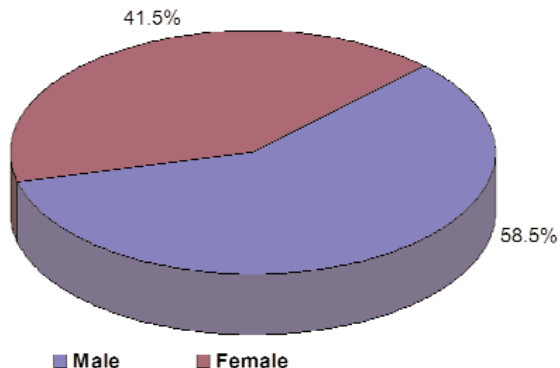
*The LRS includes 135 items comprising 18 different measures or indices of well-being, including vocational satisfaction, specific and general self-efficacy, turnover intention, emotional labor, meaningfulness of work, organizational identification, safety, availability, work-life balance, readiness for development, spiritual well-being, and adult APGAR.*



## Report Demographics

### Gender

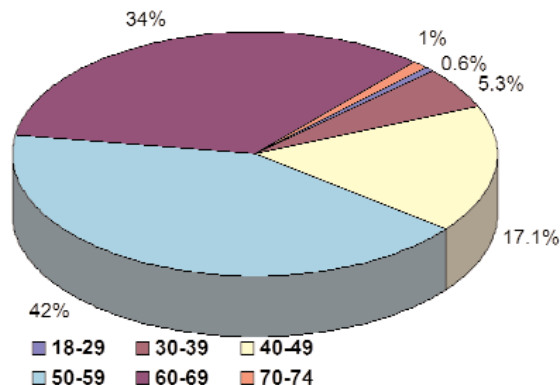
Male: 305 (58.5%)  
 Female: 216 (41.5%)



*Social support self-efficacy stands alone in its relation to marital status (higher for married/partner). Interestingly, only general self-efficacy increases with age and is related to lower levels of emotional labor.*

### Age

18-29: 3 [0.6%]  
 30-39: 28 [5.3%]  
 40-49: 89 [17.1%]  
 50-59: 219 [42.0%]  
 60-69: 177 [34.0%]  
 70-74: 5 [1.0%]

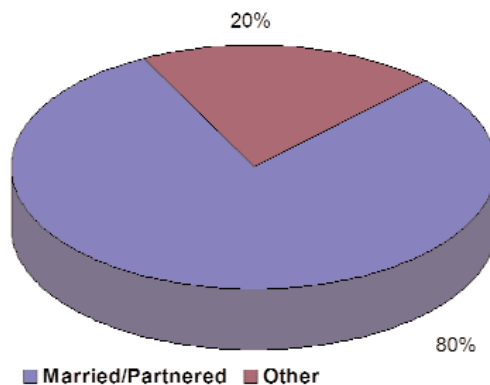


### Marital Status

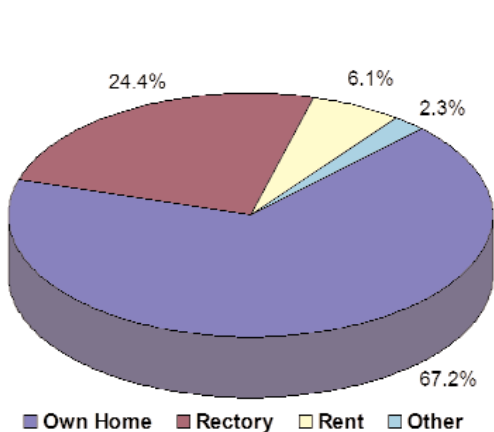
Married/partnered: 417 [80.0%]

Other: 104 [20.0%]

Note: "Other" category includes:  
 56 single,  
 38 divorced, and  
 10 widowed

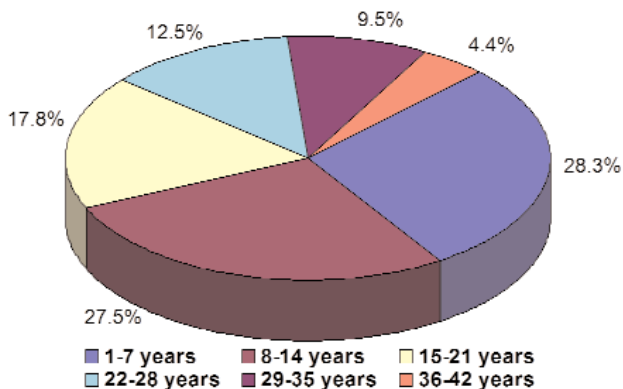


## Report Demographics



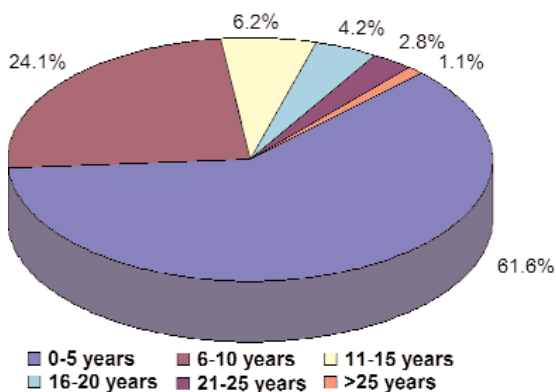
### Housing

Own home: 350 [67.2%]  
 Rectory: 127 [24.4%]  
 Rent: 32 [6.1%]  
 Other: 12 [2.3%]



### Years Ordained

1-7: 122 [28.3%]  
 8-14: 119 [27.5%]  
 15-21: 77 [17.8%]  
 22-28: 54 [12.5%]  
 29-35: 41 [9.5%]  
 36-42: 19 [4.4%]



### Years in Current Position

0-5: 266 [61.6%]  
 6-10: 104 [24.1%]  
 11-15: 27 [6.2%]  
 16-20: 18 [4.2%]  
 21-25: 12 [2.8%]  
 >25: 5 [1.1%]

*Increased tenure is positively associated with higher levels of work-life balance, support self-efficacy, vocational self-efficacy, and vocational satisfaction.*

## Analysis

While it is not the focus of this report to burden the reader with an overly detailed account of how statistical analysis was carried out, this section provides a general description. Since the data are from a number of sources (as described previously) with different collection techniques, the ways that the data are analyzed vary.

### Mayo Clinic Health Risk Assessment (HRA) Data

The Mayo Clinic HRA data are compiled for CREDO Institute by the Mayo Clinic and are made available for this study in aggregate form from a wide variety of online reports. Data were compiled on a series of Excel spreadsheets, where calculations could be made for percentage differences between the Episcopal Clergy sample (646 respondents, all from the year 2005) and a much larger “benchmark” sample of individuals from all organizations that utilize the Mayo HRA online service.

One of the greatest advantages of the Mayo Clinic HRA is its capacity to compare Episcopal clergy health data with “benchmark” percentages averaged from all other companies that use the HRA. According to Mayo Clinic staff, the benchmark consists of about 35 companies that range in size from 3,000 to 150,000 employees. The sample size of those who completed an HRA in these companies is roughly 141,000 compared to 646 in the sample for Episcopal clergy in 2005.

In comparison, the clergy sample is generally older and slightly more predominantly male than the Mayo Clinic benchmark sample and the U.S. population in general for the same age range. Seventy-five percent of the Episcopal clergy sample is 50 years of age or older, compared to only 25.9% of the Mayo benchmark sample and 33.1% of the U.S. population (between ages 18-74) who are 50 or over. The difference in male-female ratios is less pronounced, with the clergy sample being 55.3% male, while only 48.7% of the benchmark sample and 49.5% of the U.S. population is male.

Because of the older and somewhat more male sample characteristics of Episcopal clergy, some of the differences in health outcomes might be dismissed as predictable due to these differences. Thus, to compensate for these demographic sample differences, age-specific and gender-specific comparisons were analyzed to produce the findings detailed in the next section. That is, the clergy data were compared both in aggregate with the entire benchmark sample as well as only within corresponding age groupings (e.g., Episcopal clergy 40-49 years compared to benchmark sample 40-49 years) and gender groupings (e.g., female Episcopal clergy compared to female benchmark sample).

### Longitudinal Research Survey (LRS) Data

LRS variables are depicted in the Episcopal Clergy Wellness Model on Page 20 in black text as opposed to blue. To determine the nature of relationships between the variables of the Episcopal Clergy Wellness Model, correlation tables were produced that showed the sign (+ or -) and significance levels between all of its variables (see on Page 35). Where significant relationships were shown to exist between demographic characteris-

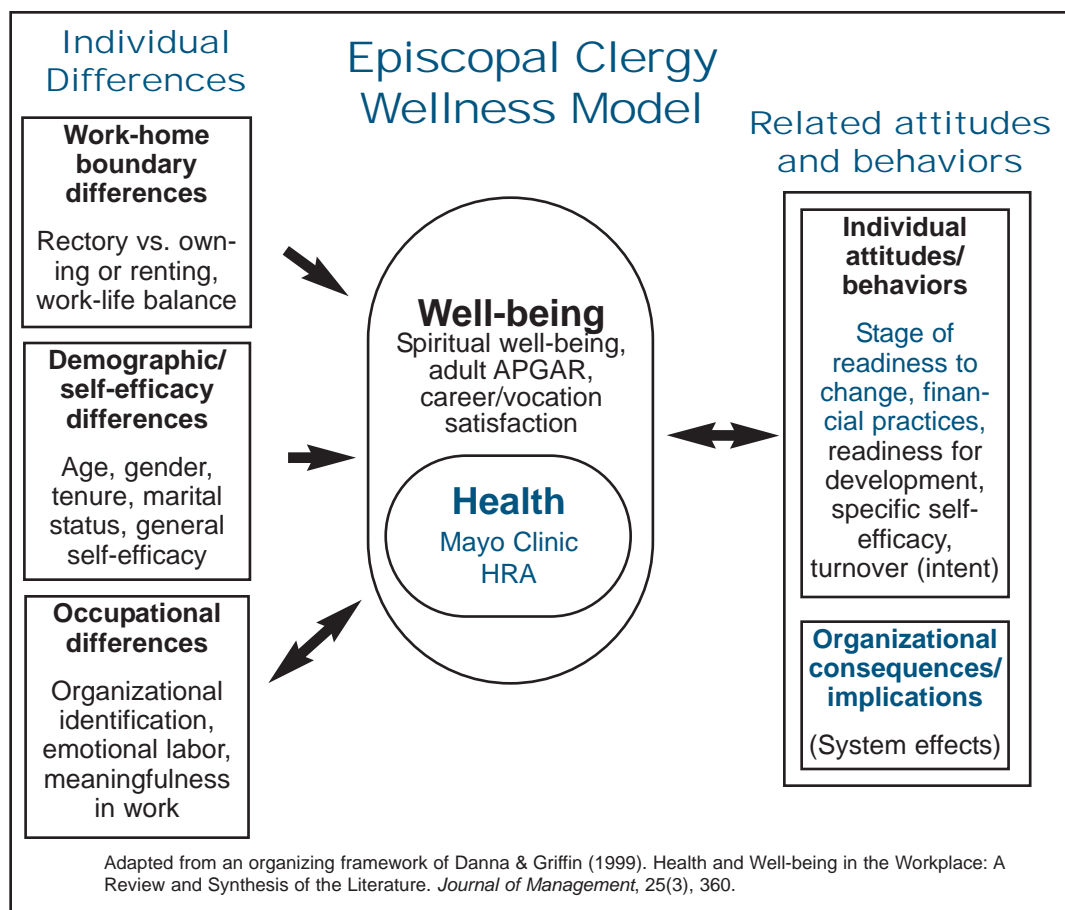
*One of the greatest advantages of the Mayo Clinic HRA is its capacity to compare Episcopal clergy health data with “benchmark” percentages averaged from all other companies that use the HRA.*

tics (e.g., age groups, marital status) and wellness variables, various statistical tests were employed to show whether a significant difference existed between groups. Predictive relationships between some variables also were tested with regression analysis, which yields the order of how influential some of the variables are in comparison with others in predicting certain levels of wellness variables. For example, higher levels of vocational satisfaction are most strongly predicted by higher levels of general self-efficacy, next by a high sense of meaningfulness in work, and least by work-life balance (although all of these are significantly related to vocational satisfaction).

In sum, analysis of the data employed a variety of methods, from comparative examination of aggregate data of the Mayo Clinic HRA to rigorous statistical tests applied to the LRS data. Both sources of data yielded valuable and interesting findings that are now more fully described in the next section.

*Higher levels of vocational satisfaction are most strongly predicted by higher levels of general self-efficacy, next by a high sense of meaningfulness in work, and least by work-life balance (although all of these are significantly related to vocational satisfaction).*

*In adapting this model, the Episcopal Clergy Wellness Model organizes clergy wellness data in an established framework that is solidly based on research findings that span the past 25 years.*



## A Model of Wellness

The Episcopal Clergy Wellness Report data and findings are situated in an adapted model of health and well-being proposed by Texas A&M University researchers Karen Danna and Ricky W. Griffin. Their 1999 review of research on workplace health and well-being continues to be an oft-cited article that offers a highly useful framework for understanding the antecedents, nature, and consequences of individual wellness. In adapting this model, the Episcopal Clergy Wellness Model organizes clergy wellness data in an established framework that is solidly based on research findings that span the past 25 years (see Wellness graph above).

We begin an overview of the Episcopal Clergy Wellness Model by starting in the left column of the figure above with three categories of differences that vary by individual: (1) work-home boundary differences; (2) individual demographic and general self-efficacy differences; and (3) occupational differences.

### Work-Home Boundaries and Work-Life Balance

First, work-home boundaries differ according to whether a priest owns/rents a residence or lives in a church-owned rectory. Work-life balance refers to the degree one balances or separates work or vocational aspects of one's life from

non-work or home aspects. The greater the level of work-life balance, the less one would generally experience work-life conflict. In some cases, a lack of work-life balance then can affect wellness and performance.

### Demographic Differences and General Self-Efficacy

Second, individuals also vary by their demographic groupings and their level of general self-efficacy. Demographic factors, such as age, gender, tenure, and marital status, can also influence well-being and health. General self-efficacy, a measure of an individual's generalized confidence in one's ability to undertake challenges and succeed at them, is known to influence many performance and wellness outcomes.

### Occupational Differences

Third, occupational differences can influence wellness.

**Organizational identification** is a form of social identification in which people define themselves in terms of their membership in a particular organization. It can also be thought of as the overlap one perceives between personal identity and organizational identity. The greater the overlap, the greater the identification. Organizational identification has been shown to influence attrition or turnover.

**Emotional labor** refers to the labor involved in displaying expected or appropriate emotions at work, and it has been shown to be related to wellness-related outcomes such as stress, burnout, and job satisfaction.

**Meaningfulness in work** is a measure of the degree to which one perceives or experiences his or her work as significant and valuable. Perceptions of meaningfulness have been linked to higher levels of individual motivation.

*Perceptions of meaningfulness have been linked to higher levels of individual motivation.*

## Definitions and Wellness Variables

"Health," "well-being," and "wellness" are three terms that are used somewhat interchangeably in the popular press and can thus lead to some confusion. To provide a more precise application of these terms, their definitions are clarified in the following sections.

**Health.** Traditionally, "health" has been defined mostly in terms of medically established, satisfactory levels of physiological or psychological indicators (i.e., physical, mental, and emotional health). Its focus has been the absence of disease – or the symptoms of disease – or the *absence of the negative*, a pathological focus (Emmet, 1991). More recently, health has been defined by the World Health Organization (1998) as a "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" – or the *presence of the positive* (cited in Danna & Griffin, 1999, p. 361). The Episcopal Clergy Wellness Model upholds this positive emphasis and defines health in terms of "specific

*The broadest term that encompasses both health and well-being is that of wellness – an overarching or umbrella term that takes into account the past, current, and desired future status of the individual’s health and well-being.*

physiological or psychological indicators” (Danna & Griffin, 1999, p. 364), not only when they suggest pathological concern, but primarily in positive terms of reaching healthy levels of these indicators. Key indicators of health in Episcopal clergy that are presented in this report were obtained from the Mayo Clinic Health Risk Assessment (HRA) and include blood pressure, cholesterol, stress level, and other variables.

**Well-being.** Well-being is defined as a holistic term that goes beyond specific symptom indicators of physical, mental, and emotional health to consider the attitudinal states that shape the “whole person” – the individual’s overall positive frame and outlook toward life, work, and prospects for happiness.

Thus, a positive focus toward wellness is fostered by defining well-being in terms of a positive attitude toward life and its potential opportunities. Key indicators of well-being are variables such as career/vocation satisfaction, spiritual well-being, and the adult APGAR (a measure of general well-being).

**Career/vocation satisfaction** is an attitudinal measure of one’s self-evaluation of satisfaction with a range of career/vocational issues.

**Spiritual well-being** incorporates two dimensions: religious well-being and existential well-being.

The **adult APGAR** scale is a concise yet rich measure of one’s general sense of well-being. It has its roots in medical research and provides a useful complement to other social-science-based measures.

**Wellness.** The broadest term that encompasses both health and well-being is that of *wellness* – an overarching or umbrella term that takes into account the past, current, and desired future status of the individual’s health and well-being.

In sum, health (physiological and psychological components) is a factor to be weighed in well-being, but well-being pushes health indicators into the background and instead puts into the foreground attitudinal states that shape a positive, holistic outlook. Thus, health and well-being emphasize relatively different domains, although they are not completely independent. Taken together, both health and well-being projected from the past, through the present, into a desired or potential future (hope), describe the state of an individual’s overall wellness.

## Related Attitudes and Behaviors

In the right-hand column of the Episcopal Clergy Wellness Model on Page 20 are individual attitudes and behaviors at both the individual and systemic levels that are related to clergy wellness. Relevant individual attitudes include readiness to change, financial practices, readiness for development, various specific types of self-efficacy, and turnover intent.



**Readiness to change** can indicate at what stage respondents consider themselves to be in relation to changing lifestyle factors that may put them at risk (e.g., smoking, weight, lack of exercise).

**Financial practices** of clergy are behaviors that impact wellness and are influenced by financial self-efficacy (described later in the report).

**Readiness for development** measures overall readiness and confidence of individuals to make transitions in their lives.

**Specific self-efficacy**, a belief in one's ability to undertake and succeed in tasks, is associated with constructive coping and success in achieving goals and performance. The types of specific self-efficacy reported here include financial, physical, vocational, spiritual, and social support self-efficacy.

**Turnover intent** refers to a clergy person's intent to leave ordained ministry.

**Organizational consequences/implications** of clergy wellness refer to the broader systemic effects that wellness interventions in individual clergy have at the parish, diocese, and Church levels.

*Taken together, both health and well-being projected from the past, through the present, into a desired or potential future (hope), describe the state of an individual's overall wellness.*

## Health Findings (Mayo Clinic HRA Data)

The health findings of the Mayo Clinic HRA are summarized in the following categories: (1) health status; (2) lifestyle and medical risk factors; and (3) stage of readiness to change. Some of the measures are based on respondents' self-reported perceptions or conditions, while others are based on more objective data such as blood pressure and cholesterol levels.

### Health Status

To provide a measure of health status, respondents were asked to complete the question, "In general, would you say your health is ...?" with the self-reported choices: Excellent, Very Good, Good, Fair, or Poor. Overall, the Episcopal clergy sample self-assessed their general health to be better than the benchmark sample, with 68.6% of the Episcopal clergy sample responding Excellent to Very Good, while only 60.4% of the benchmark sample rated themselves that highly. This held true for both males and females.

However, it is interesting to note that older Episcopal clergy respondents rated their health more highly than younger respondents. Those 40 and over rated their health as Excellent more often than the benchmark, while those under 40 rated their health less often as Excellent than the benchmark within their own age groups. The most dramatic difference was for those over 60, with 31% rating their health as Excellent compared to only 17.5% of the over-60 benchmark (a 13.5% difference). Keep in mind however, that these are self-reported assessments of health. Trends in the actual health risk data unfortunately tend to follow a reverse pattern to the overall self-perception of health, with younger respondents exhibiting less risk than older respondents, as will be seen in the following findings.

In short, this measure could be an illustration of the saying, "I'm feeling pretty good for the shape I'm in." (That is, self-reported health status seems to follow a pattern that is mostly a relative comparison of one's perceived health to an age-based prototype or even stereotype.)

### Lifestyle and Medical Risk Factors

The Mayo Clinic HRA reports provide several useful top four lists of risk factors that are indicated in the data as the highest threat to the health of the Episcopal clergy sample. Risk factors are of two types: lifestyle and medical. Definitions are in order here, as the Mayo Clinic site gives them:

**Risk Factor:** "A biological measure or lifestyle issue scientifically proved to put individuals at greater risk of illness or death or both. This HRA focuses on the 11 leading risk factors."

♦ **Lifestyle Risk Factor:** "Six of the total 11 risk factors are considered lifestyle risk factors. These include behaviors related to alcohol use, emotional health, exer-

*Overall, the Episcopal clergy sample self-assessed their general health to be better than the benchmark sample.*

cise, nutrition, safety, and tobacco use. These risk factors are directly tied to behaviors.”

♦ **Medical Risk Factor:** “Five of the total 11 risk factors are considered medical risk factors. They include medical measurements related to blood pressure, blood sugar, cholesterol, triglycerides, and weight.” (<https://mayocliniconlinestats.com>)

As also stated on the Mayo Clinic HRA website, risk factors are key indicators of subsequent major or potentially fatal medical conditions.

“Research shows that a relatively small number of health risk factors contributes to the majority of the causes of deaths among adults. This principle – that 20 percent of the health risk factors affect 80 percent of the causes of premature death – was used in selecting the risk factors included in this section. Medical research has linked the presence of the 11 risk factors represented in this section with increased risk of a variety of health problems. This information allows you to project the future state of health within your organization. These risk factors can give you a valuable profile of the health needs of your population and set a course for targeted interventions.” (See Appendix 2 on Page 44) (<https://mayocliniconlinestats.com>)

Since lifestyle risk factors are considered by the Mayo Clinic to be precursors to medical risk factors and medical conditions, the findings will be presented in that order:

### Lifestyle Risk Factors

- Alcohol use*
- Emotional health*
- Exercise*
- Nutrition*
- Safety*
- Tobacco use*

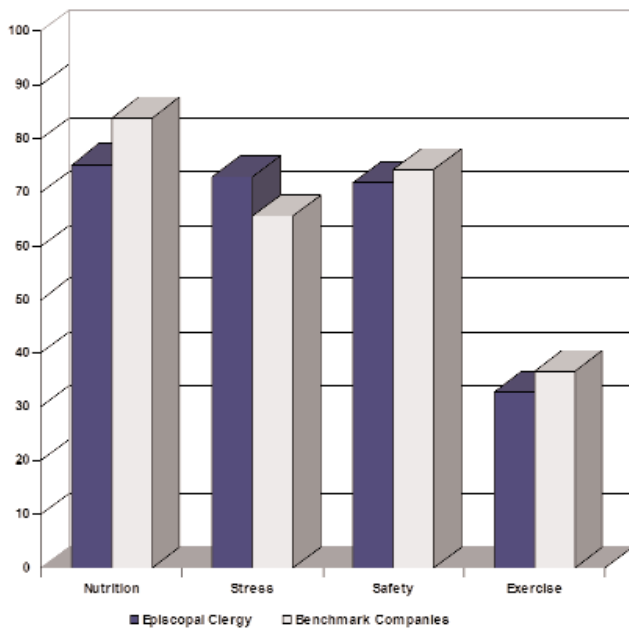
### Medical Risk Factors

- Blood pressure*
- Blood sugar*
- Cholesterol*
- Triglycerides*
- Weight*

lifestyle risk factors, medical risk factors, and reported medical conditions.

**Lifestyle Risk Factors.** The top four lifestyle risk factors that influence physical health may be linked to the medical factors that are a risk for a greater percentage of the Episcopal clergy sample than for the benchmark. For example, the lifestyle risk factor that is most prevalent for the Episcopal clergy sample is deficient nutritional habits. Yet the good news is that even though it is high, the rate of risk is 8.7% less than for the benchmark sample.

Top Four Most Prevalent Lifestyle Risk Factors by Percentage at Risk



*Consistently high levels of stress may impact medical consequences such as high blood pressure and cholesterol levels.*

The second highest risk factor for Episcopal clergy is stress. Indeed, this is the only top-four lifestyle factor for which Episcopal clergy are at greater risk than the benchmark sample.

It could be argued that such an outcome is predictable given that the ordained ministry may be characterized by situations that may inherently involve higher levels of stress. Moreover, consistently high stress levels may impact medical consequences such as high blood pressure and cholesterol levels.

Stress is a component of emotional health, defined by the Mayo Clinic as follows: "This risk factor covers stress and depressed mood. Increasing numbers of studies document the

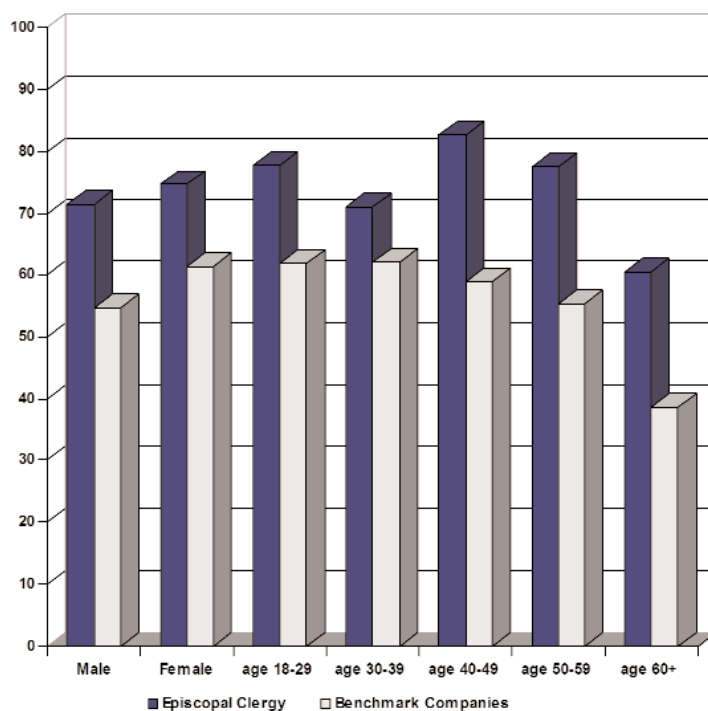
negative effects that stress can have on health. Thirty-nine percent of Americans reported adverse effects from stress" (<https://mayocliniconlinestats.com>). **Yet, it is stress more than depressed mood that is driving the higher percentage in this risk factor.** The HRA question that measures depressed mood is: "Are you feeling sad or down that you are having trouble functioning at work or in your personal life?" Only 21 people in the Episcopal clergy sample answered "Yes," 11 of whom are being treated for depression.

By contrast, 471 respondents reported having a level of 3 or greater for stress (levels that Mayo says put the respondent in the "at risk" category). **Thus, stress was an emotional health risk for 72.9% of the Episcopal clergy sample (471/646), which is 16.7% higher for males and 13.3% higher for females than the benchmark for each gender.** Moreover, stress was third in order of lifestyle risks for males (behind nutrition and safety), whereas it was first in order for females.

Regarding age differences and stress, the gap between the clergy and benchmark samples widens for those over 40, with stress levels on average 22% higher than the benchmark. However, at-risk stress percentages generally decrease as age increases beyond 40 for both Episcopal clergy and benchmark samples.

Importantly, the good news in the lifestyle risk summary is that individuals in the clergy sample are living a healthier lifestyle than the benchmark in safety risks by 2.4%, nutrition by 8.7%, and exercise by 4.0%. Yet, the percentages at risk are still high, and it would seem as though these lifestyle practices are necessary but not

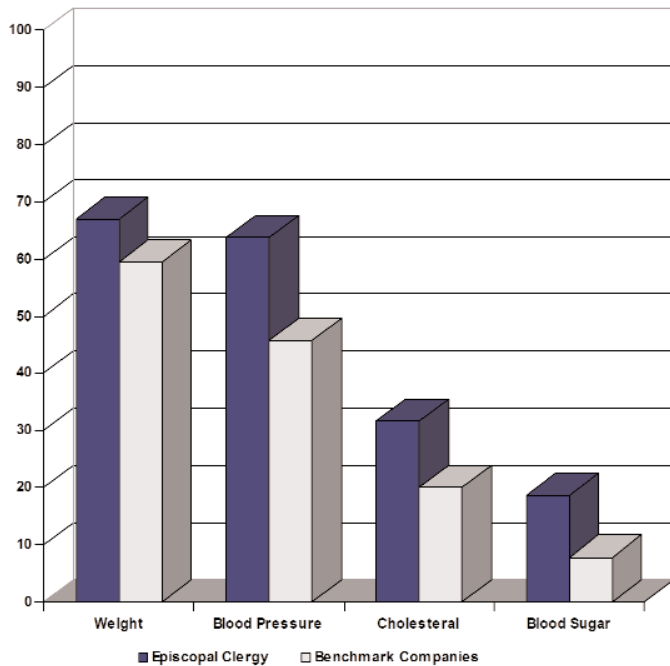
Stress by Gender and Age



sufficient to lower percentages of those who are at risk for various medical factors as follows.

**Medical Risk Factors.** Unlike the top four lifestyle risk factors, the top four medical risk factors are in much the same order as those for the benchmark,

**Top Four Most Prevalent Medical Risk Factors by Percentage at Risk**



with the exception of the fourth place, which is blood sugar for the clergy sample versus triglycerides for the benchmark. However, a notable difference is that there is a much higher percentage of clergy sample to which these risk factors apply. Additionally, cholesterol is a problem for 20% more of the clergy sample than for the benchmark.

*The total number of elevated risk factors can be a good predictor of future health problems, health care utilization and health care costs.*

Another difference is that males within both the clergy sample

and the benchmark have a different order of these factors, with blood pressure being the highest risk factor among males, and nearly 21% higher than the benchmark for males.

Medical risk factors do not vary markedly by age. In all age groups, the risk factor in which Episcopal clergy most exceed the benchmark population is in cholesterol level. A bright spot is in the category of weight as a risk factor. Even though the percentages are relatively high in both Episcopal clergy and the benchmark, Episcopal clergy are either less than or approximately equal to benchmark percentages in all age groups 30-59.

**Reported Medical Conditions.** Mayo Clinic states that lifestyle and medical risk factors are precursors to various medical conditions. The top four most prevalent medical conditions self-reported by the clergy sample are detailed as follows.

In comparison to the medical risk factors assessed by the Mayo Clinic HRA, the top four most prevalent medical conditions are self-reported conditions by the respondents. The order of the conditions for the Episcopal clergy sample matches the benchmark, but the percentage of respondents who list these conditions are, on average, 11% higher than the benchmark. The top two conditions listed by males are allergies and high cholesterol, whereas the top two conditions listed by females are allergies and depression.

## Prochaska's 5 Stages of Readiness to Change

*Precontemplation*



*Contemplation*



*Preparation*



*Action*



*Maintenance*

A paradoxical finding is that depression is reported much more as a *medical condition* (#4 with 132 respondents, or 20% of the sample) than would be predicted by the foregoing discussion of depressed mood as a *medical risk factor* associated with emotional health (only 21 respondents, or 3% of the sample). Moreover, for both males and females, depression is the medical condition in which the Episcopal clergy sample differs most from the benchmark sample. Depression varies according to gender, with more women at risk than men (27% to 15.10%), and age, with depression more prominent in those ages 50-59.

## Multiple Risk Factor Summary

According to the Mayo Clinic HRA website,

“The Multiple Risk Factor Summary provides data on the number of participants with multiple risk factors, and groups the data by risk level: low, moderate, high, and very high. The total number of elevated risk factors can be a good predictor of future health problems, healthcare utilization, and healthcare costs on an individual level, as well as for your population. ... The identification of individuals with multiple risk factors not only is a red flag for much needed intervention but also allows for the self-prioritization of these risk factors through questions about readiness to change.” (<https://mayocliniconlinestats.com>)

The “High” risk level was approximately 12% higher for the Episcopal clergy sample, shifted upward from the “Moderate” level, which was more prevalent for the benchmark sample. The difference was also greater for males than for females. In the Episcopal clergy sample, 61.9% of males had a High to Very High risk level overall (21.5% higher than benchmark), while only 46.7% of females had a High to Very High level (15.5% higher than benchmark).

As might be expected, *high to very high* multiple risk levels also generally increased with Episcopal clergy age grouping (the range was 29.1% at those levels for 30-39 years up to 62% for 60+ years). Only the 30-39 age grouping was actually better off (by 3%) at the High-Very High levels than the benchmark for their age group. Those 50-59 were at the High-Very High levels at a rate that was 13.6% higher than for their age-group benchmark, while those over 60 exceeded their benchmark by 22%.

## Stage of Readiness to Change

The Mayo Clinic website makes the following link between the Multiple Risk Factor Summary above to stage of readiness to change: “Although all risk factors are important to address, the most important risk factor may be the one the individual is ready to change.” (<https://mayocliniconlinestats.com>)

The stages of readiness to change behaviors associated with risk factors come from Prochaska’s Transtheoretical Model for Change that is used to understand and predict the likelihood of a person taking action toward behavior changes



(Prochaska & DiClemente, 1983; Prochaska, DiClemente & Norcross, 1992, much of whose research was in smoking cessation). This model postulates that change happens through a cyclical process of five stages until finally the at-risk behavior is terminated (see Appendix 3 on Page 45). Not all people are equally ready to change. Thus, different intervention strategies are suggested by the Mayo Clinic depending on the stage of change. One of the goals of any intervention program is to move individuals through the stages to maintenance of healthy behaviors.

Perhaps the most certain sign of wellness in its broadest sense is in this measure of readiness to change, for it addresses not only past and current conditions but shows how one is progressing toward the hope of a desired future state. Certainly positive findings in this regard are easy to emphasize in the Episcopal clergy sample because, in most cases, higher percentages of respondents were in the *preparation* and *action stages* of readiness to change than was the benchmark sample. Appendix 4 on Page 46 contains tables from the Mayo Clinic HRA reports that detail the percentages of the Episcopal clergy sample in the first four stages of readiness to change in the risk factors of alcohol, emotional health (stress), exercise, nutrition, tobacco use, and weight.

The good news is that Episcopal clergy were much more action-oriented in their approach to change than their benchmark counterparts. On average, Episcopal clergy were in the “action” stage of readiness to change risk behaviors (as opposed to merely contemplating change) at a rate 9.5% higher than the benchmark population. This is a positive indication of good things to come in future assessments of the Health Risk Data.

*The good news is that Episcopal clergy were much more action-oriented in their approach to change than their benchmark counterparts.*



## Well-Being Findings (LRS Data)

Findings from data collected in the Longitudinal Research Survey (LRS) are next presented in their order from left to right in the Episcopal Clergy Wellness Model (see on Page 20). As discussed earlier in the Analysis section, the goal of the LRS data analysis was to understand the direct or inverse relationships among variables as well as the relative strength (significance) of those relationships. The first category to be discussed is that of individual differences in demographic characteristics and general self-efficacy. This will be followed by findings related to work-home boundary differences and occupational factors in their relationships to each other and to the well-being variables in the Episcopal Clergy Wellness Model.

*The number of years ordained is higher for males and as age increases. The more years a priest has been ordained, the more likely he or she is to have turnover intent and to be in the married/partnered category of marital status.*

### Individual Differences: Demographic Characteristics

Demographic categories for which data were available were age, gender, marital status, and tenure (both in years ordained and years in current position). A summary of demographic characteristics of the Episcopal clergy sample is found presented earlier in the report (see on Pages 16 and 17). Findings related to how demographic sub-groups in the sample vary in terms of the various measures in the Episcopal Clergy Wellness Model are as follows.

**Gender.** In the LRS data analysis, males were found to be more likely to have higher levels of *vocational satisfaction* and *financial self-efficacy*. Statistically, this relationship was a highly significant one. In relation to *housing*, males were more likely to live in a rectory, whereas females were more likely to rent or own their residence.

**Marital Status.** Married/partnered respondents (402 married and 15 in a committed partner relationship) were much more likely to have higher levels of *support self-efficacy*. Married/partnered respondents also were more likely to be male (273 male + 144 female = 417 married/partner total). Married/partnered respondents also were more likely to have longer tenure in years ordained.

**Age.** As one's age increases, *general self-efficacy* and *turnover intent* also increases. Increase in age is also associated with increased *work-life balance*, *existential well-being*, and adult APGAR score, but a decreased level of *organizational identification*.

**Tenure (years ordained).** As might be predicted, number of years ordained is higher for males and as age increases. The more years a priest has been ordained, the more likely he or she is to have turnover intent and to be in the married/partnered category of marital status. Increased tenure

is also positively associated with higher levels of *work-life balance*, *support self-efficacy*, *vocational self-efficacy*, and *vocational satisfaction*.

**Tenure (years in current position).** Longer tenure in one's *current* position is more prevalent for males and for those with longer ordained tenure, as well as for those who are older, live in a rectory, and are in the *married/partner* category. Those with longer tenure in their current position also experience higher levels of *vocational satisfaction* and *support self-efficacy*.

## Individual Differences: General Self-efficacy

*General self-efficacy* is defined as a measure of one's confidence in ability to undertake challenges and succeed at them. General self-efficacy strongly influences the levels of all well-being variables in the model (religious and existential well-being, career/vocation satisfaction, and adult APGAR). Moreover, it is positively associated with all types of specific self-efficacy (financial, physical, vocational, spiritual, and support). It is related to *higher* levels of readiness for development, meaningfulness in work, and work-life balance, and to *lower* levels of emotional labor and turnover intent. In short, general self-efficacy is a powerful variable in terms of predicting higher or lower levels of many other variables in the model.

**The good news is that most Episcopal clergy in the sample had moderate to high levels of general self-efficacy, averaging 5.58 (on a 7-point scale).** Eighty-six percent of the sample "Agreed Slightly" to "Agreed Strongly" with statements that would indicate high levels of general self-efficacy.

## Work-home Boundary Differences

**Housing.** Episcopal clergy who do not live in a church-owned rectory (i.e., they own or rent their residences) have higher levels of *vocational satisfaction* and *work-life balance*, and they score higher on the *adult APGAR* (well-being). Interestingly, those who own or rent their housing also have lower levels of *organizational identification*. The latter relationship is possibly attributable to higher levels of identification that derive from not only working but also living in facilities that one associates with the Church.

**Work-life Balance.** *Work-life balance*, defined as the degree one balances work and non-work aspects of life, is generally higher as age increases and for those in the sample who own or rent their residences. Work-life balance is positively related in highly significant ways to all well-being variables (religious and existential well-being, career/vocation satisfaction, and adult APGAR), organizational identification, meaningfulness in work, general self-efficacy, all types of specific self-efficacy, and readiness for development. It is also associated with lower turnover intent. Thus, work-life balance is another variable that is strongly associated with many variables in the model and thus highly influential to one's level of well-being.

*Episcopal clergy who do not live in a church-owned rectory (i.e., they own or rent their residence) have higher levels of vocational satisfaction and work-life balance, and they score higher on the adult APGAR (well-being).*

*Emotional labor can be problematic in the home-work interface when people "hold in" their emotions in professional situations but then release them at home in ways that are not always helpful.*

Episcopal clergy averaged 4.8 (on a 7-point scale) on work-life balance, with half of the sample indicating a moderate to high work-life balance. Thus, the other half of the sample is neutral or "Does Not Agree" with statements that would indicate high levels of work-life balance.

## Occupational Factors

**Organizational Identification.** Organizational identification, the degree to which one's personal identity overlaps with perceived organizational identity, is a variable that relates in some surprising ways in the Episcopal Clergy Wellness Model (see on Page 20). For example, one might expect high levels of emotional labor to cause stress, which would potentially distance one from the perceived source of that stress – one's ties to the organization. However, the reverse turns out to be the case. Those with high levels of emotional labor also identify more strongly with the organization. One possible explanation is that the more one identifies with the organization, the more one is motivated to represent that organization more fully – especially by an increased effort to display emotions that are consistent with organizational (Church or vocational) norms and public expectations of those norms.

Another surprising finding is that organizational identification relates negatively to the adult APGAR measure of well-being. This is perhaps explained by the lower work-life balance levels of those who identify strongly with the organization, which would negatively impact general well-being. Less surprisingly, organizational identification relates positively to vocational self-efficacy, religious and existential well-being, and meaningfulness in work.

The mean (average) score of Episcopal clergy on organizational identification was 4.6 on a 7-point scale, with 203 of the 521 participants (39%) responding with a 5 or higher for organizational identification. Thus, roughly 40% of the sample indicates a moderate to high level of organizational identification, whereas 60% of the sample does not.

**Emotional Labor.** The most notable finding related to emotional labor is its very strong relationship to increased turnover intent. A possible explanation is that emotional labor can lead to levels of stress that can eventually become dysfunctional to performance, thus prompting thoughts of leaving ordained ministry for less stressful activities. This link is made more plausible by considering that factors intrinsic to one's job, one's role in the organization, and the home-work interface have all been found in research to be major sources of *occupational stress* (Cooper & Marshall, 1978). For example, emotional labor can be problematic in the home-work interface when people "hold in" their emotions in professional situations but then release them at home in ways that are not always helpful. Not surprisingly, higher levels of emotional labor are linked to lower levels of well-being (adult APGAR) and general self-efficacy.

The good news is that the experience of very high (or very low) levels of emotional labor is not common among Episcopal clergy. The average score on emotional labor was 4.2 on a 7-point scale, with only 14% (72 out of the 521) responding with a 5 or higher for emotional labor. Thus, the majority of responses in this measure are in the neutral to "Agree Somewhat" range (307 respondents or 59% of the sample), meaning that the majority experience only moderate levels of emotional labor.

**Meaningfulness in Work.** Meaningfulness in work is another variable that strongly influences many other variables in the wellness model. Positive perceptions of the meaningfulness of one's work relates to higher levels of all well-being variables (religious and existential well-being, career/vocational satisfaction, and adult APGAR). It is positively associated with all types of specific self-efficacy and readiness for development, work-life balance, and organizational identification. It is also related to lower levels of turnover intent.

Thus, a high level of meaningfulness in work for Episcopal clergy would indeed be a positive indicator for well-being and other beneficial variables in the wellness model. Happily, that is the clear case. The average score of meaningfulness in work was a *very high* 6.5 on a 7-point scale, with 99% (515/521) responding with a 5 or higher. Interestingly, nearly a third (159) of the Episcopal clergy sample responded with a perfect score of 7, indicating that they experienced the highest level of meaningfulness in their work.

*Positive perceptions of the meaningfulness of one's work relates to higher levels of all well-being variables (religious and existential well-being, career/vocational satisfaction, and adult APGAR).*

## Well-Being Variables

The foregoing section has detailed the relationships of individual difference variables in the left-hand column of the Episcopal Clergy Wellness Model (see on Page 20) to other variables in the model, including the various measures of *well-being* in the center column (*career/vocational satisfaction*, *religious* and *existential well-being*, and *adult APGAR*). The most interesting question at this point is which of these made the most difference in predicting levels of well-being. Through a technique known as regression analysis, the relative strength of relationships of variables to one another was analyzed. Summarized in the chart on Page 35, individual difference variables in the right three columns are listed in the order of their relative influence in predicting levels of the well-being variables in the left column (i.e., variables listed first in each of these columns have the most influence on the well-being variable in the left column). In short, we can prioritize the relative influence of the top variables related to well-being.

*Higher levels of meaningfulness in work and general self-efficacy (in that order) are most significant in predicting higher levels of religious and existential well-being.*

We see that higher levels of meaningfulness in work and general self-efficacy (in that order) are most significant in predicting higher levels of *religious* and *existential well-being*. Higher levels of general self-efficacy and work-life balance are most influential in adult APGAR scores. General self-efficacy and meaningfulness in work are most predictive of *career/vocation satisfaction*.

Somewhat surprising findings in the table are that increased tenure (years ordained) relates to lower levels of religious well-being and that increased organizational identification is associated with lower levels of adult APGAR (well-being). However, as might be predicted, *general self-efficacy*, *meaningfulness in work*, and *work-life balance* were most influential overall in predicting higher levels of the well-being variables. Thus, these three factors should receive a great deal of attention when considering how to increase levels of well-being in Episcopal clergy.

Frequencies with which Episcopal clergy reported levels of 5 or higher on the well-being variables themselves are summarized below in the table below.

Frequencies of Responses 5 or Higher on Well-being Variables			
	Sample Mean	Number Responding 5-7	% of Sample Responding 5-7
Religious well-being	6.1 (on a 7 point scale)	481	92.30%
Existential well-being	5.9 (on a 7 point scale)	468	89.80%
Adult APGAR	2.7 (on a 5 point scale)	152 (responding 3-5)	29.20%
Career/Vocation Satisfaction	5.5 (on a 7 point scale)	412	79.10%

Generally, these levels can be considered quite good and cause for celebration, with the surprising exception of the adult APGAR measure. Since the latter is a measure of general well-being, it should trace roughly along the rates for other types of well-



## Individual Difference Variables Most Predictive of Well-being

Well-being variable: most predicted by ?	Work-home boundary differences	Demographic/ self-efficacy differences	Occupational Factors	All Individual Difference Variables
Religious well-being	1. Work-life balance (+)	1. General self-efficacy (+)	1. Meaningfulness in work (+)	1. Meaningfulness in work (+)
		2. Tenure (-)	2. Organizational identification (+)	2. General self-efficacy (+)
		3. Age (+)	3. Emotional labor (-)	3. Tenure (-)
				4. Work-life balance (+)
				5. Organizational identification (+)
				6. Age (+)
Existential well-being	1. Work-life balance (+)	1. General self-efficacy (+)	1. Meaningfulness in work (+)	1. Meaningfulness in work (+)
		2. Age (+)	2. Emotional labor (-)	2. General self-efficacy (+)
			3. Organizational identification (+)	3. Work-life balance (+)
				4. Organizational identification (+)
				5. Age (+)
Adult APGAR	1. Work-life balance (+)	1. General self-efficacy (+)	1. Meaningfulness in work (+)	1. General self-efficacy (+)
		2. Gender (higher for females)	2. Emotional labor (-)	2. Work-life balance (+)
		3. Marital status (higher for married/partner)	3. Organizational identification (-)	3. Gender (higher for females)
				4. Marital status
Career/Vocation Satisfaction	1. Work-life balance (+)	1. General self-efficacy (+)	1. Meaningfulness in work (+)	1. General self-efficacy (+)
	2. Housing (higher for those owning or renting home)	2. Gender (higher for males)		2. Meaningfulness in work (+)
				3. Housing
				4. Gender (higher for males)
				5. Work-life balance (+)

*Readiness for development is a strong indicator for an individual's sense of well-being (and vice versa).*

being. One possible difference may be that the questions for this instrument are somewhat more abstract in nature and give a different response scale from the others (5 instead of 7 possible responses in the survey). Thus, the difference in well-being levels may be an artifact of the inability of the APGAR measure to differentiate responses in as fine-grained a way as the 7-point scales for the other well-being variables.

## Related Attitudes and Behaviors

**Readiness for Development and Specific Self-Efficacy.** Defined earlier in the Model of Wellness section, *readiness for development* and *specific types of self-efficacy* are similar in that they are both attitudinal and intentional variables are “drivers for change.” That is, they measure overall readiness of individuals to make transitions in their lives, as well as their confidence in their own abilities to undertake and succeed in those transitions. Additionally, both of these variables are significantly related to many variables in the LRS.

First, *readiness for development* is highly and positively related to all of the well-being variables, as well as all types of specific self-efficacy. It is directly associated with the individual difference variables of meaningfulness in work, and work-life balance. Thus, it could be said that readiness for development is a strong indicator for an individual's sense of well-being (and vice versa). Moreover, the attitude of readiness is very closely tied to confidence in one's own abilities (self-efficacy) to control and modify the financial, physical, vocational, spiritual, and social support areas of one's life. Interestingly, high levels of readiness for development were associated with much lower levels of turnover intent.

Second, all of the *specific types of self-efficacy* (financial, physical, vocational, spiritual, support) show very strong inter-relationships, meaning that individuals with high levels of one type of self-efficacy are likely to be higher in all other types of self-efficacy, as well. Thus, self-efficacy does not tend to be an attitude limited to only one area of life. Moreover, just as in readiness for development, all types of specific self-efficacy are highly related to all well-being variables, lower turnover intent, and lower levels of emotional labor.

However, specific types of self-efficacy do vary quite a bit in their relationships to other variables in the model. For example, *financial* self-efficacy is the only type related to gender (higher for males). *Vocational* self-efficacy is the only type related (positively) to organizational identification. *Social support* self-efficacy stands alone in its relation to marital status (higher for married/partner). Interestingly, only general self-efficacy increases with age and is related to lower levels of emotional labor.

**Turnover Intent.** As discussed earlier in the report, *lower* turnover intent is strongly influenced by many variables in the model: higher levels of well-being, all types of self-efficacy, meaningfulness, work-life balance, and readiness for development. This is hardly surprising in that high levels of these indicate a general sense of well-being, efficacy, and meaningfulness in one's current vocation. So why would one want to change it? Interestingly, the most significant predictor of *higher* turnover intent is increased levels of emotional labor. As discussed in the findings related to emotional labor, such dissonance between felt and displayed emotions on an ongo-



ing, occupation-related basis can potentially be a source of stress in which some might seek resolution by changing occupations.

Frequencies with which Episcopal clergy reported levels of 5 or higher on readiness for development, specific self-efficacy, and turnover intent variables are summarized in the table below.

<b>Frequencies of Responses 5 or Higher on Attitudinal/Behaviorial Variables</b>			
<b>Variables</b>	<b>Sample Mean (on a 7 point scale)</b>	<b>Number Responding 5-7</b>	<b>% of Sample Responding 5-7</b>
Readiness for Development	5.5	423	92.30%
Financial	5.3	371	89.80%
Physical	6	491	29.20%
Vocational	5.7	456	87.50%
Spiritual	5.9	469	90.00%
Support	5.7	453	86.90%
Turnover intent	2.5	40	7.70%

The good news seen in this table is the high percentage of Episcopal clergy who indicate higher levels of readiness for development and specific self-efficacy, all related to well-being, while the percentage of those indicating turnover intent is quite low.

*The most significant predictor of higher turnover intent is increased levels of emotional labor.*

**Financial Practices Summary.** Another behavioral area that can impact wellness is financial practices. A sense of self-efficacy and well-being relating to one’s financial status and prospects can impact wellness in its broadest sense. Thus, another area in which the Episcopal clergy sample completed a survey is that of their financial practices. The financial questions were asked of the Episcopal clergy sample (n=449) prior to their scheduled CREDO conference. The numbers and percentages reporting “Yes” or “No” to the following 18 financial indicators or practices are summarized in the table below.

*A sense of self-efficacy and well-being relating to one’s financial status and prospects can impact wellness in its broadest sense.*

Item (in order of “Yes” responses):	% Yes	% No
1. Know what my financial situation would be in the event of change	97.54%	2.46%
2. Have financial documents pertaining to me and my family in a place my family can find them	84.34%	15.66%
3. Established “rainy day” fund	78.79%	21.21%
4. National credit card in my name	77.85%	22.15%
5. Reviewed insurance coverage (i.e. life, auto, etc)	76.51%	23.49%
6. Discussed finances with family	75.39%	24.61%
7. If I died suddenly, my survivors know who to notify	73.83%	26.17%
8. Know what my SSI will be	71.59%	28.41%
9. Have an up-to-date will	70.92%	29.08%
10. If I died suddenly, my survivors could understand their financial picture	70.25%	29.75%
11. Putting away money to save	69.57%	30.43%
12. Know what my income would be from investments	63.09%	36.91%
13. Completed net worth statement	55.80%	44.20%
14. Understand my retirement benefits	53.69%	46.31%
15. Developing up-to-date financial plan	49.00%	51.00%
16. Analyzed cash flow	48.66%	51.34%
17. Have an updated financial plan	48.33%	51.67%
18. Authorized another person to act as power of attorney	34.45%	65.55%

As seen in the table, the top three financial practices receiving a “Yes” response are:

- (1) knowing what one’s financial situation would be in the event of change;
- (2) knowing where important documents are; and
- (3) establishing a “rainy day” fund.

The top three financial practices receiving a “No” response are:

- (1) analyzing cash flow;
- (2) having an updated financial plan; and
- (3) authorizing a power of attorney.

The good news is that financial self-efficacy (to make modifications in financial practices) is moderate to high for 71.2% of the sample.

## Wellness Contagion: The Systemic Effects of Wellness

Wellness in Episcopal clergy is not limited to individual or even local benefits but can have ripple effects to produce beneficial system-wide outcomes. Moreover, there is substantial qualitative evidence to support this assertion. While all of the wellness measures discussed thus far in this report have related to “individual” wellness, this section deals with larger, system-wide effects of individual wellness interventions. Also, the effects described are based on analysis of an additional sample of clergy. In 2004, CREDO Institute conducted an extensive and intensive evaluation of participants in three CREDO conference groups through post-conference surveys and interviews. The purpose of the periodic review was to provide a more intensive “maintenance check” on the long-term effects of CREDO on conference participants.

As part of the periodic review process, a structured interview protocol was designed to ask participants in the CREDO periodic review groups about CREDO-related changes. Fifty participants in three randomly selected CREDO groups were interviewed from 45 minutes to one hour each. Transcripts were coded and entered into a software package designed to allow manipulation and aggregation of codes. A significant finding from the periodic review was that the effects of CREDO (an individual reflection, education, and discernment opportunity) extended well beyond the individual. In other words, clergy who attended CREDO reported evidence of a “wellness contagion” effect, meaning that they observed effects of their wellness essentially spreading throughout the systems in which they lived and worked.

Systemic “wellness contagion” effects were noted in four areas:

- ♦ Spouse/partner/family
- ♦ Congregation/community
- ♦ Diocese
- ♦ The larger Church

In the spouse/partner/family area, participants reported actively engaging their spouses/partners in financial planning, physical wellness strategies, spiritual practices, and mutual planning. In the congregation/community area, participants reported returning to their congregations/communities with renewed energy and vigor and thus engaging parishioners more in congregational responsibilities, introducing new types of worship and, in general, “modeling” wellness within the parish. At the diocesan level, participants reported feeling more of a sense of identification with the diocese and a greater appreciation of diversity and individual differences within the diocese. Finally, at the Church level, participants reported recognizing an increased level of wellness awareness throughout the Church, collegiality on a national level, and an enhanced ability to deal with opportunities and challenges.

While this wellness report has focused on the state of wellness among individual clergy, it is worth noting that the periodic review described above provides an example of the potential broader benefits of an individual clergy person’s wellness on relationships, as well as on systems and organizations within the Church.

*“Systemic change is defined as ‘change that involves an ongoing willingness to examine the way we live as members one of another’ to identify the points of connection that contribute to the strength and well-being of both the church as an institution and those who share in its life.”*

*– The Rev. James C. Fenhagen*

## Conclusion

*The data provides vital information to address individual and organizational "opportunities for greatest impact" via future wellness plans and programs.*

In examining this wealth of data, we find occasion for both celebration and concern – motivation to be optimistic about present and future levels of clergy wellness as well as continuing and expanding current efforts directed at improving wellness. There are clear indications that Episcopal clergy generally have higher levels of the most important variables that are shown in this study to influence well-being (e.g., self-efficacy, meaningfulness in work, readiness for development, work-home balance). The Mayo Clinic Health Risk Assessment data clearly indicates that there are serious health risks for clergy to address. The data provides vital information to address individual and organizational “opportunities for greatest impact” via future wellness plans and programs. Moreover, there is cause for celebration in several areas of Episcopal clergy lifestyle practices relative to the general population, as well as their higher levels of readiness when it comes to taking positive actions related to their wellness. It will be gratifying to see improvements in future Episcopal Clergy Wellness Reports for which this report will serve as a benchmark.

Erich Jantsch, an Austrian astrophysicist who wrote the *The Self-organizing Universe*, once made this statement:

“To live in an evolutionary spirit means to engage with full ambition and without any reserve in the structure of the present, and yet to let go and flow into a new structure when the right time has come.”

**The analysis and interpretation of the wealth of data in this report sets a high bar for the Church in addressing the vital issues of wellness, wholeness, and holiness in its ordained leadership.** Perhaps it is time to gather our resources and strengths and move forward together with bold and substantial steps toward wellness for everyone – both ordained and lay. Perhaps it is time to flow into a new awareness that we are living beings in living systems in a universe that continues to grow and evolve. Perhaps it is time to live into wellness and wholeness as a community rooted in the reign of God.

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## Appendix 1: Glossary of Variables and Terms

**Adult APGAR:** A concise yet rich wellness measure, developed to address general well-being. It has roots in medical research and provides a useful complement to other social-science-based measures.

**Career/Vocation Satisfaction:** An attitudinal measure of satisfaction with a range of career/vocational issues (measure from Greenhaus, Parasuraman, & Wormley, 1990, *Academy of Management Journal*).

**Emotional Labor:** Emotional labor was introduced in the organizational literature relatively recently based on a landmark book by Hochschild (1983). It refers to the labor involved in displaying expected or appropriate emotions at work, and it has been shown to be related to stress, burnout, and job satisfaction (based on work by Morris & Feldman, 1996; Ashforth & Humphrey, 1993).

**Lifestyle risk factor:** Six of the total 11 risk factors in the Mayo Clinic Health Risk Assessment are considered lifestyle risk factors. "These include behaviors related to alcohol use, emotional health, exercise, nutrition, safety, and tobacco use. These risk factors are directly tied to behaviors." (<https://mayocliniconlinestats.com>)

**Meaningfulness (in work):** One's perception of the overall significance or value of one's work or tasks (based on the Job Characteristics Model of Hackman & Oldham, 1980).

**Medical condition:** This term refers to a self-report survey in the Mayo Clinic HRA of 28 medical conditions. Mayo Clinic states that lifestyle and medical risk factors are precursors to various medical conditions.

**Medical risk factor:** "Five of the total 11 risk factors of the Mayo Clinic Health Risk Assessment are considered medical risk factors. They include medical measurements related to blood pressure, blood sugar, cholesterol, triglycerides and weight." (<https://mayocliniconlinestats.com>)

**Organizational Identification:** Organizational identification is a form of social identification in which people define themselves in terms of their membership in a particular organization. This measure has been validated in other settings and has been demonstrated to have a relationship to attrition or turnover (Mael & Ashforth, 1995).

**Readiness for Development:** This scale was originally "designed to measure perceptions of psychological resources operating when adults pursue a career transition," but was adapted for a measure of general readiness for life transitions and development for the Longitudinal Research Survey. Readiness for development has two dimensions (or factors): (1) overall readiness and (2) confidence



(adapted from the Career Transitions Inventory by Heppner, Multin & Johnston, 1990, *Journal of Vocational Behavior*, also the quote source).

**Risk factor:** “A biological measure or lifestyle issue scientifically proved to put individuals at greater risk of illness or death or both. (The Mayo Clinic Health Risk Assessment) focuses on the 11 leading risk factors.”  
(<https://mayocliniconlinestats.com>)

**Self-efficacy (specific types):** Self-efficacy refers to belief in one’s ability to undertake and succeed in tasks (Bandura, 1986). Self-efficacy beliefs influence choice of goals, persistence, and attributions of causality, and are associated with constructive coping and success in achieving goals and performance. Self-efficacy is measured in the Longitudinal Research Survey in five areas: financial self-efficacy, physical self-efficacy, vocational self-efficacy, spiritual self-efficacy, and social support self-efficacy.

**Self-efficacy (general):** While self-efficacy is task specific by definition (as above), some researchers have approached self-efficacy from the perspective of a generalized attitude of confidence or a belief in one’s ability to undertake challenges and succeed at them (from Sherer et al., 1982, *Psychological Reports*).

**Spiritual well-being:** A “quality of life” scale developed by Ellison in 1983 that measures spiritual well-being in two dimensions: religious and existential well-being. “Self-esteem and spiritual well-being were found to be positively related. Negative relationships were found between spiritual well-being and individualism, success, and personal freedom.” (Ellison, 1983, *Journal of Psychology & Theology*, p. 330).

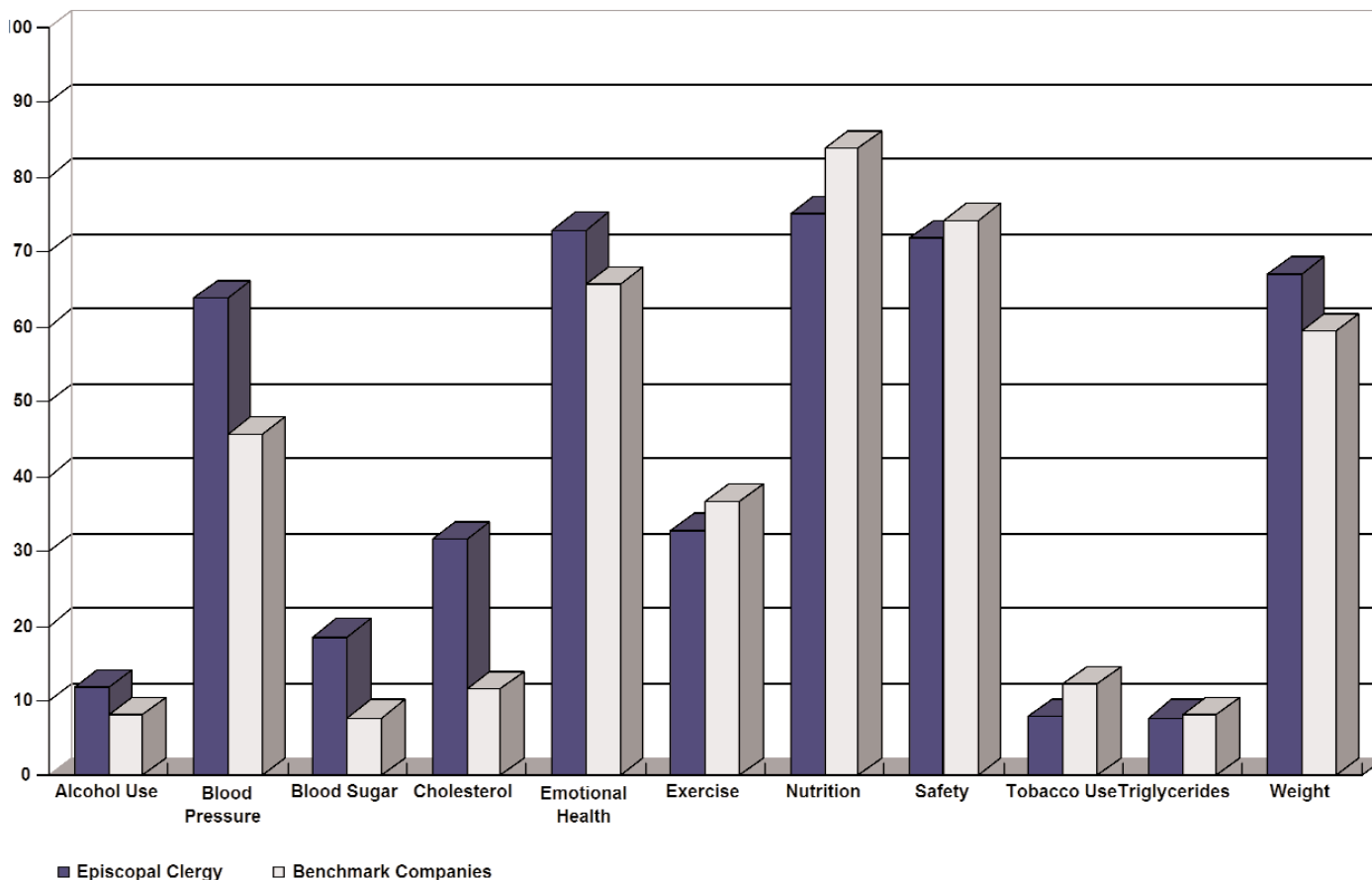
**Stage of readiness to change:** The stages of readiness-to-change behaviors associated with risk factors come from Prochaska’s Transtheoretical Model that is used to understand and predict the likelihood of a person taking action toward behavior changes (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992, much of whose research was in smoking cessation). This model postulates that change happens through a cyclical process of five stages until finally the at-risk behavior is terminated.

**Turnover intent:** A measure of whether one has ever considered or is currently intending to leave the priesthood.

**Work-Life Balance:** Work-life balance refers to the degree one balances or separates work or vocational aspects of one’s life from nonwork or home aspects. Work-family conflict and its effect on well-being and performance are commonly studied outcomes in the work-family literature (based on work of Kossek & Ozeki, 1998; Zedeck, 1992).



## Appendix 2: Mayo Clinic Risk Factors



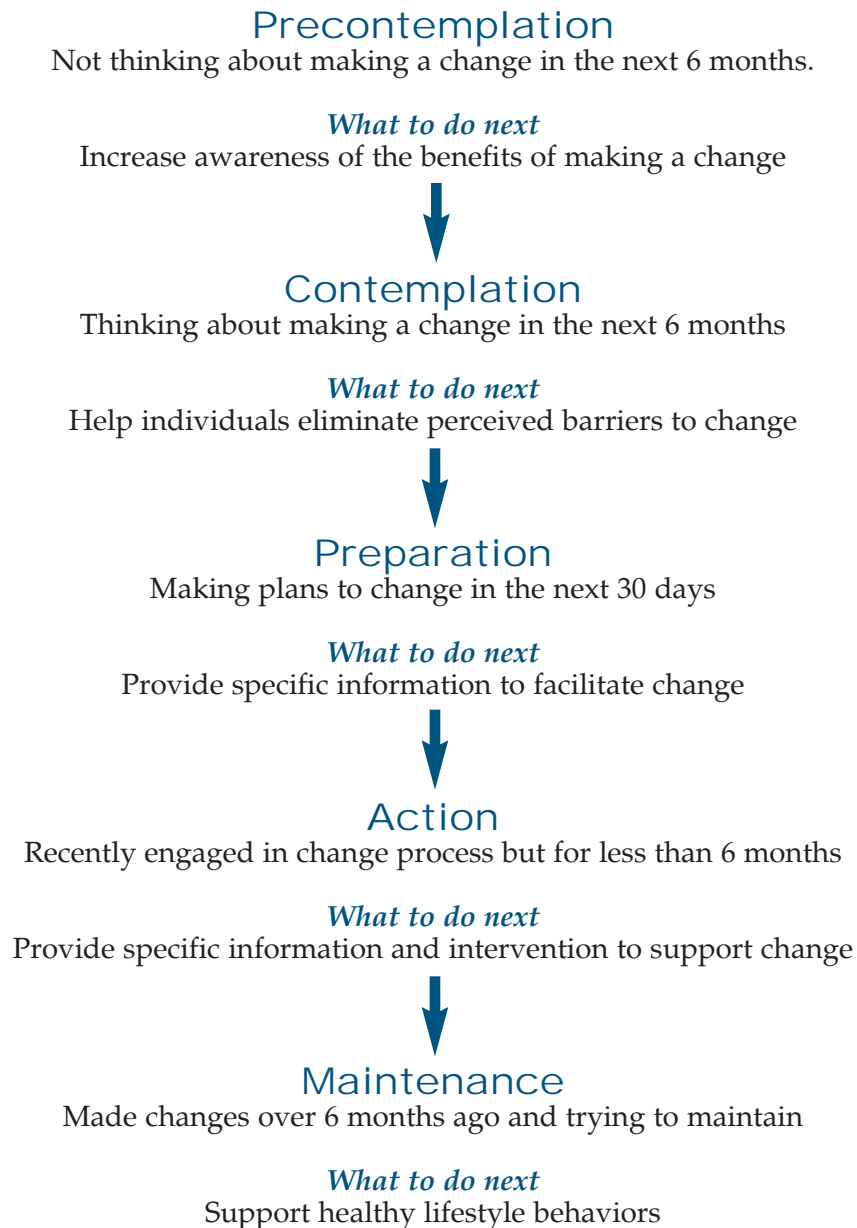
### Risk Factors\*

	Episcopal Clergy	Benchmark Companies
	Percent	Percent
Alcohol Use	11.80%	8.10%
Blood Pressure	63.80%	45.70%
Blood Sugar	18.60%	7.80%
Cholesterol	31.60%	11.60%
Emotional Health	72.90%	65.70%
Exercise	32.70%	36.70%
Nutrition	75.10%	83.80%
Safety	71.80%	74.20%
Tobacco Use	7.90%	12.20%
Triglycerides	7.80%	8.10%
Weight	67.00%	59.40%

\* A person may have multiple risk factors.

## Appendix 3: Prochaska's Transtheoretical Model for Change

### 5 Stages of Readiness to Change



## Appendix 4: Mayo Clinic HRA Tables for Stage of Readiness to Change

“This section of the HRA report will help you understand which risk factors your population is ready to change. Use this information to market, develop and design your health interventions.” (from Glossary of Terms, <https://mayocliniconlinestats.com>)

Actual numbers of clergy reporting a readiness to change are in the parentheses.

Alcohol - Stage of Readiness to Change		
Stage of Change (all)	Episcopal Clergy	Benchmark Cos.
Precontemplation	38.2% (29)	37.40%
Contemplation	28.9% (22)	22.90%
Preparation	5.3% (4)	11.00%
Action	27.6% (21)	28.70%

Nutrition - Stage of Readiness to Change		
Stage of Change (all)	Episcopal Clergy	Benchmark Cos.
Precontemplation	8.50% (41)	9.20%
Contemplation	17.70% (86)	33.40%
Preparation	16.10% (78)	36.00%
Action	57.70% (280)	21.40%

Emotional Health - Stage of Readiness to Change		
Stage of Change (all)	Episcopal Clergy	Benchmark Cos.
Precontemplation	13.5% (62)	42.10%
Contemplation	9.1% (42)	12.40%
Preparation	3.9% (18)	5.30%
Action	73.5% (338)	40.10%

Tobacco - Stage of Readiness to Change		
Stage of Change (all)	Episcopal Clergy	Benchmark Cos.
Precontemplation	19% (4)	22.20%
Contemplation	38.1% (8)	44.40%
Preparation	14.3% (3)	13.50%
Action	28.6% (6)	19.90%

Exercise - Stage of Readiness to Change		
Stage of Change (all)	Episcopal Clergy	Benchmark Cos.
Precontemplation	7.6% (16)	9.20%
Contemplation	33.2% (70)	33.40%
Preparation	37% (37)	36.00%
Action	22.3% (47)	21.40%

Nutrition - Stage of Readiness to Change		
Stage of Change (all)	Episcopal Clergy	Benchmark Cos.
Precontemplation	8.50% (41)	9.20%
Contemplation	17.70% (86)	33.40%
Preparation	16.10% (78)	36.00%
Action	57.70% (280)	21.40%



Holy God, be in my mind,  
that I might let go of all that diminishes  
the movement of Your Spirit within me.

Discerning God, be in my eyes,  
that I might see You in the midst  
of all the business that fills my life.

Loving God, be in my heart,  
that I can be open to those I love,  
to those with whom I share  
ministry and to the whole human family.

Gracious God, be in that grace-filled silence  
that lies deep within me, that I might live in Christ  
as Christ lives in me.

Amen.

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