



Seminary Students and Physical Health: Beliefs, Behaviors, and Barriers

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Abstract

As an occupational group, clergy exhibit numerous physical health problems. Given the physical health problems faced by clergy, understanding where physical health falls within the priorities of seminary students, the ways students conceptualize physical health, and how seminary students do or do not attend to their physical health in the years immediately prior to becoming clergy, can inform intervention development for both seminary students and clergy. Moreover, understanding and shaping the health practices of aspiring clergy may be particularly impactful, with cascading effects, as clergy serve as important role models for their congregants. Drawing on 36 in-depth, qualitative interviews with first-year seminary students, this study examines the complex dynamics between religious frameworks related to physical health, explicit intentions to maintain healthy practices, and reported physical health behaviors. Our findings suggest that even students who deploy religious frameworks in relation to their physical health—and who, as a result, possess positive intentions to implement and maintain healthy behaviors—often report being unable to live up to their aspirations, especially in the face of barriers to health practices posed by the seminary program itself. After reviewing these findings, we offer suggestions for physical health focused interventions, including action and coping planning, which could be implemented at seminaries to reduce the intention–behavior gap and improve clergy health.

Keywords Seminary · Clergy · Physical health · Intention–behavior gap · Action planning · Qualitative methods · Students

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Introduction

As an occupational group, clergy exhibit numerous physical health problems. They have high rates of chronic diseases, including joint disease, asthma, angina, and diabetes (Mook, 2019; Proeschold-Bell & LeGrand, 2010). These poor health indicators are likely driven by above-average rates of obesity, which have been found for United Methodist (Lindholm, 2016; Proeschold-Bell & LeGrand, 2010), African Methodist Episcopal (Baruth et al., 2014), and Evangelical Lutheran Church in America (Halaas, 2002) clergy, as well as a combined sample of Methodist, Lutheran, Baptist, and Catholic US clergy (Webb & Chase, 2019). Clergy are often around food at meetings and church events (Proeschold-Bell et al., 2011), and they eat out an average of four nights per week (Carroll, 2006). In addition, periods of high stress levels, which are often experienced by clergy (Bledsoe et al., 2013; Terry & Cunningham, 2020), can induce cravings for calorie-dense foods (Proeschold-Bell et al., 2017).

While researchers have studied the health of currently appointed clergy, few have examined health-related beliefs or behaviors of seminary students who are training for the clergy occupation. Given the physical health problems faced by clergy, understanding where physical health falls within the priorities of seminary students, the ways students conceptualize physical health, and how seminary students do or do not attend to their physical health in the years immediately prior to becoming clergy can inform intervention development for both seminary students and clergy. Moreover, understanding and shaping the health practices of aspiring clergy may be particularly impactful, with cascading effects, as clergy serve as important role models for their congregants (Anshel, 2010; Anshel & Smith, 2014).

In this paper, we describe concepts and empirical findings from research on the *intention–behavior gap* (Orbell & Sheeran, 1998; Sheeran, 2002; Sheeran & Webb, 2016; T. Webb & Sheeran, 2006) to support the philosophies and practices related to physical health among seminary students. Research on the intention–behavior gap highlights discrepancies between people’s intentions to enact healthy behaviors—such as exercise or eating well—and their actual enactment of those behaviors. A meta-analysis of existing research found that only 54% of “intenders”—those with explicit intentions to enact physical health behaviors—successfully implemented the focus behavior (Rhodes & Bruijn, 2013). The remainder—i.e., the “inclined abstainers” (Orbell & Sheeran, 1998)—failed to enact their intentions. Accordingly, this line of research suggests that intention “is a necessary but often insufficient construct to produce behavioral enactment” (Rhodes & Brujin, 2013: 305).

More recent research has identified several moderating variables and/or mechanisms that appear to facilitate greater alignment between intention and action. There is some evidence, for example, that the source and nature of people’s intentions can reduce or amplify the intention–behavior gap. Intentions rooted in personal beliefs about the benefits of a given behavior are more likely to be enacted than those based in external, social pressures (Sheeran & Orbell, 1999). Research also finds that “greater feelings of moral obligation and anticipated regret about failing to act increase likelihood that intentions are enacted” (Abraham & Sheeran, 2004; Godin

et al., 2005; Sheeran & Webb, 2016), as does the extent to which intentions are perceived to be relevant to the person's identity—e.g., seeing oneself as “an exerciser” or “an athlete” increases likelihood of exercise (Rhodes et al., 2016; Sheeran & Orbell, 2000). This research literature has implications for intentions formed in religious contexts, which may be both morally coded and identity based, and leads us to anticipate that when physical health and healthy behaviors are given transcendent meaning through religious frameworks, a reduction in the intention–behavior gap would follow (Mahoney et al., 2005).

Drawing on in-depth, qualitative interviews with seminary students, we examine the complex dynamics between religious frameworks related to physical health, explicit intentions to maintain healthy practices, and reported physical health behaviors. We do so with an eye toward how we might narrow the intention–behavior gap for this population. After reviewing the findings, we offer suggestions for physical health focused interventions, rooted in existing literature, which could be implemented at seminaries as part of broader efforts to improve clergy health.

Data and Methods

The findings outlined in this paper are based on semi-structured, in-depth interviews (IDIs) with first-year Masters of Divinity (M.Div.) students at Duke Divinity School. These interviews are part of a larger longitudinal study of the experiences of divinity students preparing for careers in religious ministry. All students entering masters level programs at Duke Divinity School in 2019 were invited to participate in a longitudinal series of surveys; 75 percent of eligible students completed all three surveys. We then used stratified random sampling to select M.Div. students from the pool of survey respondents and invited them to participate in a longitudinal series of interviews. In total, we invited 48 students and 75 percent ($n=36$) of these students agreed to participate. The final interview sample was representative of the larger M.Div. class in terms of gender, race, and denominational affiliation. Of the 36 students, 75 percent ($n=27$) were ages 21 to 29 years old, 78 percent were White ($n=28$), 56 percent were female ($n=20$), and 47 percent ($n=17$) were United Methodist. See Table 1 for details on participant demographics.

Interviews were conducted in person or by phone between November 2019 and January 2020. The interview guide covered several distinct topical areas including students' decision to attend divinity school, their sense of calling, career expectations, theological views, and physical health. In the physical health portion of the interview, we asked students to describe their personal philosophy on physical health as well as their current and pre-seminary health practices including exercise, sleep, and diet (see online supplement for full set of relevant questions). Interviews were audio-recorded with students' explicit oral consent and transcribed verbatim. Potentially identifying information was redacted from the transcripts prior to analysis, and participants were assigned pseudonyms. Students received a \$50 gift card as compensation for their time. All study procedures were approved by Duke University's Campus Institutional Review Board.

Table 1 Student demographics, in-depth interviews

Demographics (n = 36)	n (%)
<i>Age</i>	
21–29	27 (75)
30+	9 (25)
<i>Gender</i>	
Female	20 (56)
Male	16 (44)
<i>Race^a</i>	
White	28 (78)
Black or African–American	8 (22)
Other or mixed race	3 (8)
<i>Hispanic, Latino or of Spanish origin</i>	
No	36 (100)
<i>Denomination</i>	
Methodist	17 (47)
Other Protestant	12 (33)
Non-denominational	6 (17)
Other, Undecided, or No Religion	1 (3)

^aStudents selected all that applied

Transcripts were coded in NVivo 12 using applied thematic analysis approaches (Guest et al., 2011; QSR International 1999). First, a structural codebook was developed based on the interview guide and applied to the transcript text (Deterding & Waters, 2018). A team of three analysts met to discuss coding discrepancies and establish inter-coder reliability. During this time, the structural codebook was refined and transcripts re-coded as needed. This paper is based on a second round of inductive, thematic coding conducted on transcript portions identified as relevant to the topic of “physical health.” On average, this topic covered a fifth of the full interview (with a range of 14–28% code coverage). Two analysts reviewed this material to identify emergent themes and collaboratively developed a thematic codebook. These content-based codes were then applied to the text by a single analyst to ensure consistency in code application. Themes related to physical health were summarized in analytical memos.

Findings

Early in our analysis, we identified resonance between students’ responses and research on the *intention–behavior gap* (Sheeran & Webb, 2016). As a result, we use this framework to organize and interpret the findings. First, we describe the most common religious frameworks students used to describe their personal philosophy of physical health. In doing so, we demonstrate that religious frameworks can emphasize *or* de-emphasize the importance of physical health. Second, we show that despite giving their bodies and physical health transcendent (religious)

meaning, many students reported failing to enact healthy behaviors. Third, we identify important ways in which seminary itself presents barriers and challenges to enacting health behaviors.

Religious Frames for Physical Health

Many of the Divinity students we spoke with spontaneously (without prompting) used religious language to frame their personal philosophy of physical health. In total, 19 of the 36 interviewees (53%) made a connection between their faith and their physical health during the interview. In several different ways, students described caring for their bodies as a spiritual responsibility and saw their bodies and/or their physical health “through the lens of faith” (Doug).

Some respondents discussed their physical health through the language of stewardship. For example, Sharice said the following about her body: “It’s a gift and it’s my responsibility to maintain that gift. I don’t want to live my life in a manner in which I am asking God for miracles for something that I just need to steward well.” Logan also used the language of stewardship. She reported, “You’re a steward over your body the way you are a steward over that [your mental health], and everything else. To me, it is important to maintain good physical health and wellness.” Karen shared a similar perspective: “Well, ‘God only gave you one body, and you need to take care of it,’ I guess is my overall philosophy ... Get enough sleep, eat properly, get exercise.” These students describe their bodies as a gift from God, one which they are tasked with caring for and maintaining. Under this framework, healthy behaviors, such as eating properly and exercising, become a means to “honor God,” as one student, Josh, told us.

Others, echoing biblical language (1 Cor. 6:19), described their bodies as “holy” or as a “temple” in articulating their personal philosophies on physical health. For example, Emma reported, “You want to take care of the body that you have while you’re here because I think it is a place that you’re supposed to kind of treat as holy.” Another student, Patrice, reported that physical health behaviors are “a fairly big priority.” She continued,

I think that our body as a temple is very important ... And I think that’s a message of the gospel to people that are called to be a people of God. Those things make evident God to the world. So, for instance, if I’m in my best health ... then I’m able to share my testimony with how God healed me and how that makes me be accountable to my health ... I think it’s very important.

In addition to framing the body as holy, Patrice also linked her physical health to her ability to “make evident God to the world.” She felt “accountable to [her] health” as a foundation for ministry and evangelism—in short, as a means to testify to God’s presence and action in the world.

Some students reported that their physical health was important because of its relationship to other forms of health, including their *spiritual* health. Jennifer, for example, said she thinks physical health is “very important,” and noted, “I think that my physical health and how I treat my body is directly related to all the

others, like my mental and spiritual health, and I see taking care of my physical body as a Christian responsibility.” Paul shared a similar perspective:

I think that physical health is integral to the health of the whole person. I think that I am not a soul who has a body. I am a body. So, I think that if I don't take care of my body well, then I'll feel the consequences of it both physically, which is important, and also mentally and spiritually, and all that.

For both Paul and Jennifer, physical health is a necessary foundation for spiritual health. Because they are deeply intertwined, these students framed physical health practices as a “Christian responsibility.”

While religious frames were most commonly used to articulate positive intentions related to physical health behaviors, one student used a religious framework to justify a *lack* of concern for his physical health. When asked about his personal philosophy regarding physical health, Chris responded,

I do not place as much emphasis on my physical wellbeing as on my, I guess, mental wellbeing ... I always justify this in my mind by [the Apostle] Paul saying like, “Hey, physical training is of some use, but training godliness is *the* thing.” I'm like, “Hey, I'm training in godliness.” Physical training, eh, that's all right ... I don't want to be fat, of course. Like I'm not going to let myself get there, but I guess, meh. We're all bound to die eventually.

Rather than seeing physical and spiritual health as intertwined, Chris described his physical health as separate from and even at odds with “training in godliness.” Chris uses a religious frame—the words of the Apostle Paul from the New Testament—to justify a lack of attention to the body and its care.

Two other students also referenced religious frames that de-prioritized physical health in their responses. In both cases, however, these respondents positioned themselves in opposition to the perspective being described. Caleb, for example, reflected,

A common belief, whether it's expressed or not, among especially Christians ... is that my body is just something I have, that exists to serve my spirit ... that what really matters is some invisible spiritual realm, and that the physical is just incidental to that. I think that translates itself into people who work too late, sacrifice sleep so that they can produce some information or product ... It's just such an upside-down way to live, what time is for, and what money is for, and what your body is for.

The “common belief” identified by Caleb is similar to the one articulated by Christopher, above. Caleb, however, says he opposes separating one's spirit from one's body. Regardless, his response demonstrates that some religious frames, perhaps even ones that are “common,” suggest physical health should be de-prioritized or ignored relative to other concerns.

Benjamin referenced a similar perspective on physical health when asked what, if anything, he would change about the local church. Benjamin responded,

I would say, leaning in to support the pastors more ... There is a theology ... called Docetism which is the idea that Jesus didn't really have a body, he was more of a spiritual being. And I think that a lot of churches approach their pastors with a "Docetious" view and they forget that pastors are humans with physical bodies that need to be taken care of sometimes.

Here, Benjamin references a religious frame—the "Docetious view"—to explain why churches, denominational leaders, and the laity sometimes fail to prioritize the physical health of clergy.

These three examples demonstrate that not all religious frames for making sense of the body and physical health encourage positive health behaviors and/or intentions toward them. In fact, participants felt that some philosophies, rooted in theological ideas that emphasize the separation between the physical and the spiritual, explicitly discourage people—pastors and/or the laity—from prioritizing their physical health. Generally speaking, however, we found that religiously infused physical health philosophies (e.g., gift, temple, foundation) tended to be associated with positive personal values and intentions toward healthy behaviors. In other words, students used religious frames, such as stewardship and/or the body as a temple, to describe physical health as a Christian responsibility and/or as a foundation for spiritual well-being and formation and, as a result, these students aspired to enact healthy practices.

It also important to note that not all students used religious frames in discussing their physical health. We found, for example, that more men (44%) than women (30%) used a religious frame in talking about physical health. We also found that fewer Methodist-affiliated students (24%) used this kind of language than their non-Methodist counterparts (47%). Finally, we saw descriptive differences by race, with fewer White students (24%) using this language than Black and/or mixed-race students (64%). These findings suggest that social groups and upbringing may shape students' exposure to and use of religious frameworks for physical health.

The Gap Between Intentions and Actions

Despite narratives demonstrating that students embraced religious frames and generally extolled the value of physical health, many of the students we spoke with also reported struggling to follow through on their intentions. Emma, for example, who felt that you should treat the body "as holy," (quoted above), also reported, "I think that physical health is important. That doesn't mean I am necessarily physically healthy." Emma's response points to the discrepancy between people's values or beliefs related to physical health and their actual behaviors. Even among students who ascribed transcendent meaning to the body and physical health, many still struggled to enact their intentions.

When asked about his personal philosophy toward his physical health, Josh reported, "I definitely feel like the classic 'God's temple' toward [my body], so I want to take care of it well and honor God through that." Yet, Josh also identified discrepancies between his beliefs, intentions, and behaviors. Despite trying "to be relatively health," he reflected,

I still eat pretty bad, but I at least take insulin with it ... I also want to be working out, stuff like that. I've done a pretty lousy job since the first time I filled out the [survey]. I was at that phase where I was going to the gym three times a week. Now, I go to the gym every 3 weeks. It happens ... I'm planning on going again now things have kind of died down ... try to get back in the rhythm.

Josh uses a religious frame—"God's temple"—to describe how he understands his physical body and says this leads him to *want* to care for his body as a way to "honor God." He also had clear *intentions* to do so, evident throughout his response in the language of trying, wanting, and planning. Despite this, however, Josh still struggled to eat and to exercise in line with his values and intentions.

Benjamin described a similar tension between his aspirations and his behaviors in practice. He noted, "Ideologically, I would love my health to be first, but, practically, it doesn't always happen." Instead, Benjamin said that in practice, if he was going to "set a list of priorities," school would come first, church and congregation second, and health third. He reflected, "And that's not good. I don't like that, but realistically I think that's where I fall whether on purpose or on accident." When asked *why* he wanted his health to come first, Benjamin drew a connection between his physical health and his ability to perform well in his calling: "The short answer is that it's kind of difficult to function as a student, as a pastor, if your health is garbage." However, despite aspirations to move his health higher on the priority list and a belief that his physical health was an important foundation for his ability to perform ministry effectively, Benjamin felt unable to do so in the face of a myriad of practical challenges: "Deadlines. Late night phone calls. Meetings lasting 3 hours long so you don't have time to cook."

Jennifer, who views "taking care of [her] physical body as a Christian responsibility" (above), reported that she tries "to be active as much as possible." However, Jennifer also reported that she is not always successful: "Exercise? Definitely part of my life. Goes in and out. So, first couple weeks of school ... I'd run two or three times a week. Last 2 weeks, didn't go to the gym because I was busy." Jennifer aspired to maintain a regular exercise routine but also found that it "goes in and out," usually in response to external demands. Jennifer was not alone. Michael reported, "When things get really busy and stressful, I will say that those [physical health behaviors] are probably the first thing to go." Michael, like Josh, reported that maintaining a healthy body was an "honoring way to live for God." However, despite giving transcendent meaning to their physical health and health practices, students like Michael, Jennifer, and Josh also admitted that exercise and healthy eating were often the first things to go when they were busy or stressed. These students' comments suggest that the demands and constraints of being a seminary student negatively impacted their ability to enact their intentions related to physical health practices—a point we take up in the next section.

Seminary as a Barrier to Healthy Behaviors

Respondents described a range of barriers that prevented them from enacting their values and following through on their intentions. For many students ($n=21$), divinity school itself presented barriers, including the disruption of pre-existing habits and routines which caused them to backslide on some or all health behaviors including diet, sleep, or exercise. The workload and structure of the seminary program also made it difficult for students to prioritize or maintain healthy habits, despite intentions to do so.

Emily, who told us that she “struggles with chronic illness,” illustrates these challenges clearly. Emily feels that she has to “think about diet, exercise, sleep, all of that” more than other students because of her preexisting health issues. She told us: “I’m lucky ... I came here knowing those things—the importance of prioritizing your health and knowing your limits.” Despite this knowledge and experience, however, Emily also described many challenges and even failures she experienced trying to maintain healthy behaviors when she began graduate school. She reflected,

I definitely had to readjust my daily routine when I came to seminary ... A big thing is recognizing it is physically impossible to do all the readings, all of the assignments. How can I discern what to prioritize and what not to? ... My first 2 weeks here, I was forgetting to eat, because I was just working, working, working. And I was staying up and falling asleep on the couch on my textbook.

Emily said she eventually “had to set alarms at each meal time” to remind her to eat because she was forgetting so frequently. She also set reminders to give herself insulin because “there were times when I would forget ... I was just so busy and stretched thin that I would stop, quickly run, make a salad, come back and start reading, and then before I knew it, I was done eating, and I totally forgot to give insulin.” Emily attributed her forgetfulness to the intensity of her new workload, “My mental capacity was full ... I was just having to think about so much.”

Emily also struggled to get regular exercise, something she previously found easy to do. While an undergraduate student, Emily would “go workout” when she was “stressed or when I got a break.” In divinity school, things changed. As she noted,

Yeah, that didn’t happen here because I never finished and got a break, and I was always stressed. So, I had to learn to plan to exercise, which was new for me ... if I just waited for the opportunity [to] present itself, it never would.

Like diet, medicine, and sleep, Emily reported having to become more conscious and deliberative about exercise if she wanted to live in alignment with her values and intentions. Her prior habits and routines did not work anymore, and she was forced to create external structures to maintain healthy behaviors.

Other students also described starting seminary as a disruption in their prior routines and described being currently in the process of establishing new routines. Lula, for example, described fairly clear intentions related to physical health that involved drinking water, eating a balanced diet, getting some exercise, and sleeping well. She then explained,

Now, the only exercise I've incorporated since I've been here is just walking all over the place. By the time the day is over, I'm just really tired, so mostly I just go home. But I do believe in exercise ... and something I have to reincorporate, that I had before I started divinity school, was yoga. I love it.

Lula, like other students we spoke with, reported discrepancies between her intentions and her behaviors in the present: She "believe(s)" in exercise but right now, only gets exercise by "walking all over the place." Lula reported that she is simply too tired to do anything else. However, she also intends and hopes to "reincorporate" exercise practices that she enjoyed and did regularly before starting seminary.

Darryl shared a similar story. He reported that while in college, "I had a set routine ... I was a student athlete, I had to go to bed early. But now, transitioning to Duke and grad school, getting sleep is harder for me, just because of the workload and the environment. I'm starting to have a routine down, a little bit. I mean, every single day is different for me." Darryl felt that he was able to maintain healthy behaviors—like regular exercise and sleep—as an undergraduate *because* he was a student athlete. Obligatory practices, external accountability, and a set daily routine forced him to maintain healthy habits. However, now in graduate school, without external structures and obligations, he has to establish a new routine on his own. Darryl feels this has been more difficult "because of the workload" but also because of "the environment" and lack of consistent structure ("every single day is different for me").

For the students we spoke with, coming to seminary disrupted their preexisting habits and routines. Seminary coursework, as Tammie told us, operates on a "different type of schedule" than they were used to, often with classes at different times each day, making it hard to maintain a consistent daily routine. Students like Tammie were still trying to "wrap [their] heads around it." Moving to a new place also required navigating and becoming comfortable in new spaces. For some students, this was intimidating. Hannah, for example, reported, "I've been scared to go to the gym here. I hate trying new things. I'm scared to go to the gym by myself." Beyond this, the increased workload also made healthy habits difficult. Students found it difficult to find the time and energy to eat healthy foods or exercise after a day of courses. One student, Sharice, also felt the stress associated with coursework caused her to eat less healthy foods: "I'm stressed and so I'm seeking comfort from what I'm eating."

Paul, who reported being able to maintain healthy habits, told us that he felt he was able to do so "in spite of the divinity school." He reflected,

Sometimes, it's in spite of the divinity school, which is funny, because we had a whole spiritual formation retreat just talking about Sabbath, that was mandatory for the divinity school. We had these spiritual formation groups that constantly tell you about maintaining your health ... Then, that all goes out the window come midterm season, you know? It's like, aren't these the same professors that were telling me this stuff?

Paul's comments point to the sometimes-conflicting messages about health that students at the Divinity School received. While being told about the importance of

health practices, in practice, students felt that faculty and staff prioritized academics over health. As another student, Kyle, told us: “I think one of the downsides of being at a place that’s very heavily academic is that it is a life of the mind and sometimes at the expense of the life of the body.”

While Divinity school can present challenges to maintaining healthy behaviors, it can also be a place where new interpretive frameworks related to the body are transmitted. Brandon, for example, when asked about his personal philosophy on health, responded,

Honestly, I’ve never thought about it ... I thought about it really hard for the first time a couple of days ago with one of my pastoral care readings about burnout in the ministry and the idea that you have to take care of yourself to be an effective pastor physically. I’m like, “Huh, yeah.” I’ve thought about it in terms of taking care of yourself, but I haven’t established a philosophy for that, I guess.

Brandon reported that he had not given much explicit thought to his physical health and its importance (or lack thereof); however, exposure to readings that frame physical health as an important foundation for effective ministry prompted him to think more about this issue. These comments point to the important role that seminaries can play in shaping students’ beliefs and behaviors related to physical health.

Proposals for Action

What can seminaries do to promote positive values, intentions, and behaviors related to physical health among seminary students? In this section, we build on our core findings (as outlined above) to offer several proposals for action. First, our findings—in line with existing research (Bopp et al., 2013; Jacobson, 2014; Webb et al., 2013)—suggest that religious frames vary in terms of the degree to which they encourage people to prioritize or de-prioritize physical health. Seminaries that aim to promote physical health among their students should explicitly encourage religious frames that promote health and actively counter those that do not (Walther et al., 2015). In doing so, seminaries can also explicitly communicate the importance of physical health to being a successful religious leader. Frames which link identity to physical health practices, like those that link religious leadership, ministry, and calling with health, would likely be most successful in reducing the gap between intentions and behaviors (Rhodes et al., 2016; Sheeran & Orbell, 2000). Brandon’s comment in the section above suggests that this is already happening to some degree within the Duke program and has had an impact on students’ beliefs and intentions in relation to physical health practices. Our findings demonstrating variation in students’ use of religious frames, however, suggest that there is room for seminaries to further promote this perspective.

Our findings also suggest, however, that interpretive frameworks that imbue the body and its maintenance with spiritual meaning are not enough to ensure that healthy behaviors are implemented and maintained, especially in the face of significant barriers like heavy demands on time from work, school, and family

responsibilities. The vast majority of seminary students in our interview sample reported that they value their physical health and recognize the importance of maintaining physical health behaviors to successfully manage the demands of professional Christian ministry. And while many students deployed religious frames related to physical health, for some this was not sufficient to overcome the gap between intentions and actual behaviors. Simply drawing attention to that discrepancy (Anshel, 2010) may not be enough to help students implement and/or maintain healthy behaviors during and/or after divinity school, as many students are already aware of the gap between their intentions and behaviors.

One promising solution for aspiring clergy is providing opportunities for students to consciously and explicitly *plan* how they will implement healthy behaviors, anticipate challenges and barriers to doing so, and develop coping strategies to overcome those challenges (Araújo-Soares et al., 2009; Sniehotta et al., 2005). One model, which distinguishes *action planning* and *coping planning* (Sniehotta et al., 2005), seems particularly promising. Action planning “can help initiate action by specifying when, where and how to act” (Sniehotta et al., 2005). Coping planning, on the other hand, asks participants to imagine potential barriers to desired actions and develop detailed plans for overcoming them. As prospective forms of self-regulation, both action and coping planning require time and resources. We suggest that seminaries encourage and provide opportunities for concrete action and coping planning as part of broader efforts to improve health among seminary students and clergy. Research suggests that planning may be particularly important and effective during times of transition, such as entering or leaving seminary, or, for clergy, transitioning to a new appointment or occupational role.

By way of example, we share a story from David. David described a common challenge many clergy face on the job—frequent events involving (unhealthy) food and communal eating (Carroll, 2006). He explained,

I did a field placement in a church in rural North Carolina ... And they fed me and fed me and fed me and I gained, no joke, like 20 something pounds this summer. Yeah. And that’s a lot of eating. And it was like fried chicken filled with gravy and everything deep fried, you know? The worst stuff for you and I got to school and I was like, “I can’t wear any of my pants.” ... I felt physically like crap.

David described this experience as a “big wake up call.” He started back at school with a clear intention to make healthier choices in the future. He reported, “I can’t just do that. I need to be living healthier, eating healthier, working out, not just sitting on the couch.”

However, the intention to do better next time may not be enough. David could benefit from engaging in both concrete action and coping planning. To do so, David would first further clarify his desired actions and intentions. What would it look like to live and eat healthier? What does “working out” look like for David, and when and where will he do so? Action planning involves translating vague aspirations (“living healthier”) into concrete and specific behavioral intentions. Second, David would imagine the kinds of barriers he is likely to face in maintaining healthy behaviors and then outline detailed strategies for what to do when and where those

challenges occur. For example, if David is often invited by congregants to talk over a meal, he could have ready a list of places with healthy options. Or, he could review menus of common meeting spots in advance to identify the healthiest options so that he does not need to rely on an in-the-moment decision. When attending church functions where he anticipates there will not be healthy options—and where refusing what has been offered would be considered rude—David could have a clear plan to limit portion size and skip dessert (or take a doggie bag home). If David anticipates that he may often be on the road between visits or churches, he could prepare by always keeping healthy snacks in his car and office. Anticipating these challenges in advance and devising strategies for dealing with them eliminates the need to deliberate in-the-moment when it is more difficult to make good choices.

Action and coping planning would be beneficial just before or soon after students enter seminary. Ideally, planning-related interventions would occur during orientation or even sooner, so students can identify local exercise options and test out healthy on-the-go snacks and meals. Recognizing that graduate school is a busy, stressful time, this planning process could make students aware of the health facts most relevant to them, such as: stress fuels increased eating and also increased weight retention; the physical cues of tiredness and thirst are often misinterpreted as hunger, leading to more eating; physical activity in general and not just “exercise” has been shown to be good for health; and physical activity as well as sleep can help one’s mind work better. Relevant planning could then follow—for example, making a list of relatively easy-to-prepare and enjoyable meals that can be brought to campus, or scheduling walks and frequent but brief physical activity while studying.

Pressure to excel and make good grades will likely be high, and, as seen from this study’s interviews, some students will focus on grades to the exclusion of self-care, even when they value both. One approach would be to help students discern their hopes and values related to graduate school in advance, and to foster a growth mindset. A growth mindset is the belief that one’s intellectual abilities are not set but can instead be shaped. Students who believe that intelligence is fixed have higher levels of cortisol, a stress indicator, when grades are declining (Lee et al., 2019). In contrast, college students with a growth mindset in a recent study experienced less stress during online learning caused by COVID-19 policies (Mosanya, 2021). Seminary faculty could remind students at key points during the semester that: learning challenges are expected in graduate school; students, with effort, will grow and learn; and feeling challenged is appropriate and does not signal any lack of appropriateness of being in graduate school. Faculty could repeatedly send the message that the true measure of success is growth, not grades. This perspective may help students keep the larger picture of their *holistic* formation in mind and prevent them from abandoning healthy practices to prioritize good grades.

Importantly, seminaries (and denominations) could also consider broader changes that would make it easier for students (and clergy) to maintain healthy behaviors. Community health capacity models suggest there are three interrelated processes for promoting health: (1) activating existing community resources for health, for example, in the form of individuals’ expertise and the setting’s infrastructure; (2) expanding the community’s health-promoting assets; and (3) empowering community members, in this case, students, to control health problems and priorities (Stokols

et al., 2003). Steps one and two typically involve changes at the extra-individual level, for example, at interpersonal, community, institutional, and policy levels (McLeroy et al., 1988). The current study can provide guidance on areas to target. For example, we found that seminary itself, which mirrors life as a pastoral leader (Carroll, 2006; Carroll et al., 2014), by nature of having inconsistent days, heavy workload, and disrupted routines, gets in the way of student's ability to maintain healthy behaviors. While inconsistent days may be inevitable, seminaries might preserve a mid-day hour for exercise and offer a room for students to lead an exercise class, should they choose. Seminaries might subsidize healthy food options or make them easily accessible on campus, while also offering a fridge and healthy options in campus vending machines. Building in an occasional class-free weekday that is a 'break day' or 'catch up' day might help relieve some pressure. These kinds of structural changes shift the burden of maintaining healthy practices off of individuals and onto institutions and communities.

Seminaries can also signal institutional support for healthy practices in a variety of other ways, such as seminars focused on health and well-being.¹ Summer field education is another occasion to intervene. In an unpublished study, we had students log their observations during internship placements and debrief twice (mid-summer and end-of-summer). Students named many health lessons about what they hoped to do (and not do) once on the job. In a similar program, students could be encouraged to observe how their pastor-mentor handles a variety of health-related aspects, from negotiating the potluck line to vacation-taking. Finally, there is strong evidence for the efficacy of peer support in health behaviors (Ginis et al., 2013). In a seminary setting, the school could pair upperclassman with incoming students and set a schedule for them to meet for general advice and support, including instructions to discuss sleep, exercise, eating, and how to handle high-stress periods. Alternatively, during orientation, students could sign up for a kind of exercise they like, such as walking or running, and the seminary could facilitate an initial event where students have a chance to identify potential exercise partners. These are just some of the many possibilities. Ultimately, a combination of supports for student health at individual, interpersonal, and institutional levels will yield the best results (Paskett et al., 2016; Stokols et al., 2003).

¹ Duke Divinity School does offer some programs related to health, although not all students are required to attend. For example, a weekly lunch series called Ministerial Formation Thursdays was held for multiple years to provide practical knowledge of ministry work, and several talks per year focused on well-being. Currently, a webinar series called Wind in Our Sails includes sessions on friendship (social support), spiritual practices for well-being, and resiliency skills. This paper is based on interviews with entering students who would not yet have participated in these programs but may have had some exposure to health-related discourse at orientation, in their courses, or in conversation with more advanced students.

Discussion and Conclusion

Our findings suggest that even students who deploy religious frameworks in relation to their physical health—and who, as a result, possess positive intentions to implement and/or maintain healthy behaviors—often report that they are unable to live up to their aspirations, especially in the face of barriers to health practices posed by the seminary program itself. This study therefore supports recent work on the intention–behavior gap (Sheeran & Webb, 2016). Still, religious frames that actively discourage a focus on the body and physical health are likely to translate into lower buy-in for students in the kinds of interventions we suggest. We have argued that planning-based interventions would likely work best when combined with exposure to and engagement with theological ideas that position the body and its care as a spiritual responsibility. Moreover, we argue that programs targeting student health are most likely to be successful if they take a multi-pronged and multi-level approach, addressing individual, social, cultural, and institutional barriers to healthy behaviors.

Studies and interventions focused on the physical health of seminary students are important for several reasons. First, seminary programs may be a particularly effective time and place to change health practices. Seminary students are a relatively captive audience, one that is particularly amenable and open to new ways of thinking and doing. Likewise, seminary students—especially those who attend residential programs—are, by definition, in a transitional period. As students transition into the program, their prior routines and habits are disrupted. While this can present a challenge to pre-existing health routines, it can also serve as an opportunity for students without those routines to consciously and deliberately establish new, healthy habits and/or eliminate unhealthy ones. Finally, seminaries may be particularly well-suited (relative to other kinds of graduate programs) to offer didactic courses that encourage health through a combination of transcendent (theological) framing and practical strategies.

Second, improving the health practices of students would provide a strong foundation for when they later become clergy. Clergy have high rates of chronic diseases (Mook, 2019; Proeschold-Bell & LeGrand, 2010), and some of the stressors clergy face are similar to those encountered by students. Both have fragmented days (Proeschold-Bell et al., 2011), which makes it hard to establish patterns and feel like work is being accomplished. Both feel called to their work, which makes it likely that they will routinely over-extend themselves (Pargament & Mahoney, 2005; Proeschold-Bell & Byassee, 2018). In other words, the very identity that might encourage students to adopt a theological framework of health may also encourage them to sacrifice sleep and other healthy behaviors. Students and clergy both lack time to prepare nutritious meals, and clergy in particular have frequent evening meetings and a lot of driving to pastoral visits (Carroll, 2006). Helping students ingrain healthy behaviors during the difficult rhythm and demands of graduate school may well help them sustain healthy behaviors later as clergy.

Finally, a number of recently proposed health interventions point to congregations and clergy as key sites and sources for encouraging healthy practices

in their communities (Abbey & Keogh George, 2020; Anshel, 2010; Anshel & Smith, 2014; Baruth et al., 2015). As trusted leaders and authorities, clergy and chaplains can be influential role models for their congregants and wider community, potentially leading to broader ripple effects. But the impact of pastors on the behaviors of those under their care depends on whether or not clergy “practice what they preach” (Anshel & Smith, 2014; Bopp et al., 2013). Seminaries, as spaces in which aspiring clergy are being formed (their values and approaches to ministry), have the power to make positive and lasting impacts on clergy’s values and beliefs related to physical health, establishing a foundation that can shape whether and how they make physical health a priority, not only in their personal lives but also in their ministry. Despite this potential, recent research suggests that “there is a relative lack of health promotion resources available to seminary students” and “environmental and policy supports for health also were relatively minimal (smoking, vending machine policies)” (Bopp & Baruth, 2014, 2017). Interviews with clergy across denominations report minimal or no instruction on health during seminary training and a desire for greater focus on self-care (Webb et al., 2013). We hope this study encourages additional research and new programs focused on physical health at seminaries.

Study Limitations

This study has several important limitations. First, this study is based on interviews with students from one divinity school—a residential program with a relatively young student population—which may skew the findings. The majority of students in our sample (75%) are under 30 years of age. These individuals may still be in the process of articulating their core values and establishing routines and habits that align with them. Some of the mismatches between values, intentions, and behavior may simply reflect common experiences among young adults, especially those who are transitioning out of their time as undergraduates and into the next stage of life. However, we believe that action and coping planning would be useful for students and clergy across the career and life cycle.

Second, while students in our sample come from a variety of denominational backgrounds, the majority are United Methodist and nearly all are Protestant. The findings outlined here, especially in relation to religious frames for physical health, are not necessarily generalizable to other religious groups. That being said, the practices suggested here (e.g., action and coping planning) may be relevant or applicable to professional training in other communities and even in adjacent professions as well. For one, the struggles and challenges faced by Divinity school students may also be common among other graduate and professional students in other fields. Clinical psychology graduate students have shown a reluctance to practicing self-care themselves, despite their goal of increasing the well-being of clients (Schwartz-Mette, 2009). Medical and dentistry students globally have adequate knowledge about health and the importance of healthy behaviors, and yet fall short in applying this knowledge personally (Tufail et al., 2020). A study of 2,683 graduate students across all graduate programs at two large public United States universities found

they sleep an average of 6.4 h per night, with 38% indicating less than good sleep quality; both sleep duration and quality buffered emotional exhaustion, a component of burnout (Allen et al., 2021). Regardless of field, facilitating healthy behaviors is an important aspect of setting students up for success during graduate school and beyond. This study identifies a range of interventions that could be usefully deployed within seminaries and beyond.

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Declarations

Conflict of interest The authors have no relevant financial or non-financial interests to disclose.

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