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# The Prevalence and Severity of Depression Among Clergy in Kenya

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## Abstract

Depression among clergy is yet to be fully studied, especially given that pastoral work is a highly regarded profession where clergy are seen as the gatekeepers of society and the last port of call when congregants face challenges, including mental health problems. The clergy also face stigma and isolation when they try to seek psychological interventions (Noel & Due, 2019). Thus, the prevalence of depression among clergy remains largely unexplored. The purpose of the current study was to explore the prevalence and severity of depression among clergy in Kenya. Both census and snowballing techniques were employed to recruit the 135 clergy members from mainstream churches affiliated with Love INC., Kenya, of which 123 (88 male, 35 females; 26-65 years) gave full questionnaire responses and were thus eligible for the study. A descriptive research design was used to collect data using a researcher-generated socio-demographic questionnaire and Beck's Depression Inventory II (BDI-II) to assess depressive symptoms. Data was analyzed quantitatively using descriptive and inferential statistics utilizing the Statistical Package for Social Sciences (SPSS 29). The findings showed that the prevalence of depression was 52% (n=64) of the clergy showing signs of depression, of which 29.3% (n=36) had mild depression, 7.3% (n=9) had borderline clinical depression, 12.2% (n=15) experienced moderate depression, and 3.3% (n=4) suffered from severe depression. Depression prevalence was statistically similar between genders (female 54.3%, male 51.1%). However, age played a significant role ($\chi^2$ (4) =10.94, p=.027), with younger clergy aged 26-35 years (72%) and those aged 46-55 years (56.8%) showing higher rates of depression. The findings indicate that over half of the clergy had depressive symptoms, with the younger clergy and middle-aged showing vulnerability. However, contrary to previous findings, both genders had statistically similar rates of depression. The study thus recommends targeted mental health interventions for clergy based on age group susceptibilities and a focus on some gender-based risk factors for depression that could be addressed through psychotherapy. The study thus offers insight into clergy mental wellness that could guide future interventions.

*Keywords:* Pastor, Clergy, Depression, BDI, Prevalence, Severity, Sociodemographic,

Mental health

## Introduction and Background

According to the World Health Organization (WHO), “Health is wealth, and there is no health without mental health.” (WHO, 2021). A WHO multi-stakeholder gathering convened by the Ministry of Health examined data on mental health issues in Kenya. It revealed that one out of four persons who seek healthcare in Kenya have a mental health disorder (WHO, 2021). The WHO report on the mental health situation ranked Kenya (3.8% prevalence rate) fifth among African countries, with the highest number of depression cases (WHO, 2017). The economic costs of these health losses are also substantial.

The Christian community is not immune to depression and depressive symptoms (Proeschold-Bell et al., 2013), and the clergy profession is unusual in the sense that it combines role pressures with a higher calling, jeopardizing mental health. Clergy constitute a high-risk, often neglected group of people. A clergy may not be able to effectively assist churchgoers in managing their stress if they are unable to handle difficulties in their own lives (Terry & Cunningham, 2020). Because of the high standards and demands set for them, they are more vulnerable to mental health issues, including depression (Biru et al., 2023).The clergy is one of the best examples of a calling with unlimited work hours, and deciding which tasks to prioritize and which course of action to take might be challenging (Proeschold-Bell et al., 2023). The pastor has leadership obligations, public criticism, and limited breaks; therefore, it is an emotionally taxing profession. When a family or community faces a crisis, clergy are frequently the first to respond, providing care and support, especially for those who are dealing with severe mental illness (Proeschold-Bell et al., 2024). However, only a few studies have used validated measures to assess depression incidence rates among the clergy.

The prevalence of depression may vary across studies based on the sample characteristics, and regions may show varied rates of depression. The assessment tools also vary across studies, where some have utilized various versions of the BDI with different cut-off points or the PHQ-9. What is important is that a qualified clinician validates the symptoms, or that more than one tool is utilized to confirm the symptoms.

Depression among clergy has been scantily researched, but a few previous studies can give an overview of the phenomenon. In the United States, findings suggest that clergy may experience higher depression rates compared to the general population. For instance, Proeschold-Bell et al. (2013) conducted a study among United Methodist clergy in North Carolina, achieving a 95% response rate (n=1,726), with 38% participating via telephone interviews. The study found that 8.7% of the clergy experienced depression, which was significantly higher than the 5.5% rate seen in the general population. Likewise, Eagle et al. (2019) reported a 10.8% depression rate among clergy, more than double the national average of 3.8%. The Shaw et al. (2021) study in Florida, USA, revealed a clergy depression rate of 12.9%, as opposed to the national average of 7.1%. They additionally found that clergy members who experience work-related stress are more likely to show symptoms of depression. According to Kansiewicz et al. (2022) study, 39.8% of Assemblies of God pastors in the USA had mild to severe depression. As the leaders of their communities, clergy members have a duty to support individuals in their hour of greatest need, such as during mourning. Consequently, there are more severe societal ramifications when pastors experience professional struggles or depression since they may not be able to assist others (Milstein et al., 2020). The Schaeffer Institute surveyed the welfare of 8,150 evangelical and Reformed ministers in the USA. They found that 35% battle depressive symptoms, 54% work over 55 hours a week, 57% cannot pay their bills, and 53% believed their seminary education had failed to equip them for the mission appropriately (Krejcir, 2016). These results emphasize the need to address the elevated levels of depression among clergy.

Previous research revealed even higher depression rates. Knox et al. (2005) discovered that between 18-20% of Roman Catholic clergy exhibited signs of depression. A follow-up study by Knox et al. (2007) found that 41% of 44 Roman Catholic clergy in the U.S. showed depressive symptoms, using the Symptom Checklist-90-Revised. Many researchers have suggested that these elevated rates could be due to potential response biases. Although there is limited research on clergy depression in Europe and Asia, a few studies from Africa have offered some insight. Solomon et al. (2020) surveyed 84 Seventh-Day Adventist pastors in southern Nigeria, using the Patient Health Questionnaire (PHQ-9) to assess depression, and found a 19% prevalence (n=16).

In one of the few prevalence studies in Kenya, Machogu et al. (2022) observed that four out of the fourteen priests in the deanery in Nairobi, or 28.5%, either suffered from depression or

depressive-related disorders. Additionally, a study by Omungo et al. (2020) assessed 160 senior clergy members from four mainline Christian denominations using the Becks Depression Inventory (BDI II). They found that 52% (n=83) experienced mild to severe depression, with about 5% suffering from chronic depression. Despite these findings, there remains a substantial gap in research on clergy depression, particularly outside of Africa. The studies conducted in Nigeria and Kenya provide valuable insights into clergy's mental health challenges, but the research scope is still limited. More comprehensive and comparative studies across diverse cultures and regions are necessary to understand the global incidence of clergy depression and its underlying causes. This gap underscores the urgent need for further research on this critical issue.

Psychological health is a double problem for people in Christian leadership positions. On the one hand, psychological resilience and mental strength are considered necessary character attributes for pastors and parishioners. In contrast, several elements intrinsic to pastoral ministry mitigate against them. Frequently, this leads to a confrontation of intrinsic and extrinsic expectations, which can result in severe crises and chronic depression (Noel & Due, 2019).

Despite lacking formal and thorough education in mental healthcare, clergy frequently encounter similar employment demands as mental health professionals, such as treating clients with serious mental illness and substance misuse (Young et al., 2003). Consequently, Holaday et al. (2001) observed that pastors endure equivalent stress levels to other mental health providers. Helping trauma victims can also psychologically and physically impact the clergy, who frequently endure cognitive and behavioral effects of secondary traumatic stress (Hendron et al., 2012, 2014). Furthermore, most clergies provide services under challenging circumstances involving crisis response and maltreatment, which can result in elevated amounts of clerical distress (Bledsoe et al., 2013). These persistent and resource-intensive employment demands have numerous effects on the clergy. In addition to these duties, clergy frequently experience significant levels of employment insecurity. According to Tanner et al.(2013), the services of 28% of pastors in the United States will be terminated involuntarily at least once throughout their tenure. Due to the highly relational and very personal nature of the job of the clergy, involuntary terminations in this sector can be exceptionally distressing, causing pastors and their dependents (if applicable) to migrate and "start over" in developing connections and a faith community (Tanner, 2015,

2017). Persistent high work demands and low job stability among pastors can negatively impact on their physical, mental, and spiritual well-being.

According to Noel and Due (2019), the clergy has long working hours, frequent community and church demands, and a lack of private personal space, mainly if residing in a home adjacent to a church. Since the generosity of others provides their salaries, they experience feelings of guilt when taking "time off," especially when they fail to meet or counter strong but conflicting expectations. Other challenges include social isolation, physical and psychological fatigue, financial concerns, conflict, and politics inside the congregation. Additionally, spouses' pressure to fulfill stereotypical roles and frequent relocation necessitates the transfer of children to new schools and other family-related stresses, leading to the emotional rollercoaster of ministry. In their efforts to protect the spiritual health of their parishioners, clergy frequently disregard their wellbeing, which causes them to experience frequent distress and other well-being issues (Halbesleben & Buckley, 2004). Consequently, their lack of self-care can negatively affect their households and churches. Typically, congregants seek assistance from pastors to manage daily life crises such as the death of a loved one and other sources of stress. A clergy member unable to manage similar issues may be inefficient at assisting parishioners in their suffering.

Scholars have concluded that perfectionism or flawlessness is a risk factor for psychiatric predicaments like depression and anxiety (Xie et al.2019). When it comes to individual accomplishment, flawlessness is described as the establishing and aspiring for exceedingly high ideals of personal achievement and an excessively critical appraisal of self (Frost et al., 1990). "Be as flawless as your heavenly Father is," Jesus tells His disciples in Matthew 5:48 (NIV). Hart & Waller (2016) claim that the Greek term telios, rendered as 'perfect,' is best translated as 'complete.' They say we should seek completeness in Christ rather than impossible flawlessness. Perfectionism can appear as sanctity and enthusiasm for Christ when it is an endeavor to earn rather than express grace. They also state that fastidiousness dehumanizes us by equating our worth, identity, and appeal to our performance. It hides inner insecurities, such as a desire to avoid criticism, fear of relinquishing control, and a feeling of inadequacy. Presumably, perfectionism can also be used as a safety strategy that promises long-lasting validation while stifling any remaining self-esteem.

Proeschold-Bell et al. (2011) observed that pastors, in particular congregations, might lack social support or opt not to disclose their private lives with congregation members and denominational leaders. The reluctance may be due to fear of being perceived as spiritually unfit to fulfill their priestly function. Because of the demands put on them by themselves and others, clergies are considerably more prone to suffer from depression than individuals in other professions. Clergy members face a range of complex responsibilities, including grief counseling, balancing competing expectations from congregation members, and delivering a weekly sermon that exposes them to criticism (Proeschold-Bell et al., 2013). The difficulty of these activities is further exacerbated by the need to switch between them rapidly. In their study of the Methodist church in North Carolina, USA, Miles and Proeschold-Bell (2013) found that clergy members' guilt about not achieving enough at work and doubt about their vocation to the ministry were significant predictors of depression. Clergy with less social support were more likely to acquire depression; those who saw themselves as socially isolated were also more likely to suffer depression. Moreover, they observed that pastors frequently intertwine their personal lives with their ministry to such an extent that their mental well-being relies heavily on the health of their ministry. When pastors believe their ministry is successful, they may experience strong positive emotions to protect them from mental discomfort. They may, however, get despondent when things do not go as planned (Miles & Proeschold-Bell, 2013).

Charlton et al. (2009) posit that clergy could be candidates for Major Depressive Disorder from the pulpit if parishioners who are already suffering from the illness display a loss of interest or enjoyment in the message or the services being presented. This presentation would be considered a secondary trauma experience for clergy and could impact a pastor or clergy leader's psychological health. Avent et al. (2015) found that among the African American community, which includes African American pastors, there is a global stigma rather than an individual stigma connected with getting treatment, especially for mental health difficulties. In other words, avoidance seemed more inwardly driven, while stigma appeared externally motivated, with African Americans experiencing stigma. As a people, they do not seem to understand the importance of professional mental health. In another study by Breslau et al. (2017), mental illness and depression were culturally characterized and typically viewed as a spiritual issue rather than a "disease" in Hispanic/Latino faith-based groups. Hence, indicating

that Hispanics had a very low perceived need for mental health treatments, regardless of the degree of illness.

Along with congregational and family expectations, it appears that pastors sometimes place unreasonable demands on their personal lives. They probably push themselves to meet unattainable standards. When they cannot meet these obligations, they may experience depression, hopelessness, and frustration. Eventually, the pressure to please may manifest as stress and despair. In light of these prevailing mental health concerns among clergy, the current study thus sought to investigate the prevalence and severity of depression among clergy in Kenya. This will hopefully create awareness and lead to proactive measures and ongoing interventions to help the clergy contending with mental health issues.

## Methodology

This descriptive research study collected data on the prevalence of depression among clergy in Kenya. The sample was recruited from Love in the Name of Christ (Love INC.), Kenya, an umbrella organization encompassing clergy from the mainstream Christian churches. All the clergy (n=120) who attended the annual conference and were willing to participate were recruited into the study, and additionally, there were referrals (n=40) recruited through snowballing. In total, 150 questionnaires were mailed out, but only 135 responded, of which 123 were eligible for inclusion in the study since they had complete responses to the questionnaires. The respondents comprised 88 males and 35 females, with an age range of 25 to 65 years. They were from 12 Counties in Kenya, namely Kisumu, Nakuru, Kiambu, Kajiado, Nairobi, Mombasa, Machakos, Uasin Gishu, Kakamega, Busia, Bungoma, and Meru. The data was collected virtually using a researcher-generated social demographic questionnaire and Beck's Depression Inventory-II (BDI-II). The BDI-II has high validity and reliability, as ascertained by several studies worldwide (Jackson-Koku, 2016; Wideman et al., 2013). The BDI-II has also been used in a previous study in Kenya (Omungo et al., 2020) to collect data on depression among clergy. Data was analyzed quantitatively using the Statistical Package for Social Sciences (SPSS) version 29, and findings were presented in tables using descriptive and inferential statistics.

**Results**

To investigate the prevalence of depression among the Clergy, Beck's Depression Inventory (BDI-II) was administered, and the total scores were obtained. The study determined that a lower cut-off of 10 points would indicate mild depression, based on the fact that most clergy may find it hard to disclose issues regarding their psychological well-being due to the nature of their work, which demands them to offer solutions to their congregants' issues (Salwen et al.,2017). Omungo et al. (2020) also used a cut-off of 10 for the presence of depressive symptoms. The findings are presented in Table 1.

*Table 1: The Prevalence of Depression Among the Clergy*

| Depression Status | N | % |
|---|---|---|
| No depression (0-9) | 59 | 48% |
| Depressed (10-63) | 64 | 52% |
| Total | 123 | 100% |

Table 1 displays the frequencies and percentages of the clergy who were considered to have no depression (total BDI scores 1-9) and those who met the cut-off for various levels of depression based on this study (BDI scores 10-63). Overall, the prevalence of depression was (52%) (n=64), which implies that slightly over half of the clergy had depression. The prevalence of depression was further assessed based on age, gender, and marital status. Findings are presented in Table 2.

*Table 2: The Prevalence of Depression Based on Gender, Age, and Marital Status.*

| Socio-demographic Variables | | Depression Status | | | | Chi-Square |
|---|---|---|---|---|---|---|
| | | Normal | | Depressed | | |
| | | N | % | N | % | |
| Gender | Female(n=35) | 16 | 45.7% | 19 | 54.3% | $\chi^2$=.100 |
| | Male(n=88) | 43 | 48.9% | 45 | 51.1% | df=1 |
| | Total(n=123) | 59 | 48%) | 64 | 52%) | *p*=.752 |
| Age | 26-35(n=25) | 7 | 28% | 18 | 72% | $\chi^2$=10.94 |
| | 36-45(n=31) | 16 | 51.6% | 15 | 48.4% | df=4 |
| | 46-55(n=44) | 19 | 43.2% | 25 | 56.8% | *p* =.027* |
| | 56-65(n=17) | 13 | 76.5% | 4 | 23.5% | |
| | Over65(n=6) | 4 | 66.7% | 2 | 33.3% | |
| Marital Status | Married(n=102) | 52 | 50.9% | 50 | 49.1% | $\chi^2$= 2.27 |
| | Singles(n=14) | 5 | 35.7% | 9 | 64.3% | df=2 |
| | S/D/W(n=7) | 2 | 28.6% | 5 | 71.4% | *p* =.322 |

The findings in Table 2 show the prevalence of depression based on gender, age, and marital status, where regarding gender, depression prevalence among the males and females was statistically similar (females: 54.3%; *n*=19; males: 51.1%; *n*=45; $\chi^2$ (1)=.100, p=.752). There were differences in the prevalence of depression based on age groups ($\chi^2$ (4)=10.94, p=.027) where within each age group, the highest prevalence was among the 26-35-year-old (*n*=18;72%), 46-55-year-old (*n*=25;56.8%) and the 36-45-year-old (*n*=15;48.4%). Hence, the prevalence of depression was higher among the younger clergy. Regarding marital status, the prevalence of depression among the Separated/Divorced/Widowed (S/D/W), the single, and the married varied at (*n*=5;71.4%), (*n*=9;64.3%) and (*n*=50;49.1%) respectively. Thus, the majority of the S/D/W and singles were depressed, and almost 50% of the married were depressed, although the differences in prevalence were not statistically significant based on marital statuses ($\chi^2$ (2)= 2.27, *p* =.322).

Both gender and marital status did not emerge as significant factors in depression prevalence. Still, age appeared to be a critical determinant, with younger clergy members exhibiting higher rates of depression. This finding suggests that younger individuals within religious communities may face unique stressors or challenges that contribute to elevated levels of depressive symptoms.

The Severity of Depression

The scores of depression in the BDI-II were categorized to determine the severity of depression, as shown in Table 3.

*Table 3: The Severity of Depression Among the Clergy*

| Depression Severity Levels | N | % |
|---|---|---|
| Mild depression (10-16) | 36 | 56.3% |
| Borderline clinical (17-20) | 9 | 14.1% |
| Moderate (21-30) | 15 | 23.4% |
| Severe (31-40) | 4 | 6.3% |
| Extremely severe (41-63) | 0 | 0.0% |
| Total Depressed | 64 | 100% |

Table 3 displays the frequencies and percentages of the severity of depression among the clergy who met the criterion for depression(n=64). Mild depression had the highest representation

(n=36; 56.3%), followed by moderate depression (n=15; 23.4%), then borderline clinical depression (n=9;14.1%), and those who had severe depression were the least at n=4(6.3%). The study further determined the severity of depression by determining the mean depressive score by gender for the single, married, and S/D/W by their age groups, as shown in Table 4.

*Table 4: Severity of Depression by Gender within the Age and Marital Status Categories*

| Gender | Age (in years) | Marital status | N | Mean | Standard deviation |
|---|---|---|---|---|---|
| Female | 26-35 | Single | 5 | 18.2 | 10.38 |
| | 36-45 | Married | 2 | 26.50 | 2.12 |
| | | SDW | 1 | 14.00 | |
| | 46-55 | Married | 7 | 17.29 | 4.72 |
| | | SDW | 2 | 19.50 | 13.43 |
| | 56-65 | Married | 2 | 14.00 | 4.24 |
| Male | 26-35 | Married | 9 | 19.22 | 8.24 |
| | | Single | 4 | 18.50 | 7.05 |
| | 36-45 | Married | 12 | 15.17 | 4.69 |
| | 46-55 | Married | 14 | 18.21 | |
| | | SDW | 2 | 18.00 | |
| | 56-65 | Married | 2 | 15.00 | |
| | Over 65 | Married | 2 | 15.00 | |

Table 4 shows that for the females, the highest depression was among the married 36-45-year-old clergy (M=26.5, SD=2.12), while for males, it was among married 26-35-year-old (M=19.22). The 26-35-year-old female had slightly lower depression scores (M=18.2, SD=10.38) compared to the 26-35-year-old males (M=18.5, SD=7.05). Thus, it seems that among the 26-35-year-olds, the noted high depression scores were mainly from the married male clergy. For the 36-45-year-old male clergy, depression scores were almost half (M=15.17, SD=4.69) for the female clergy in the same age group (M=26.5, SD=2.12). The 46-55-year-old SDW female clergy had higher depression scores (M=19.5, SD=13.43) than the males in the same category(M=18). Depression was lowest among both genders for those in the 56-over 65+ years (55-65 and over 65 years) category, and they were all married. Thus, among the married clergy, the 26–35-year-old married males and the 36-45-year-old married females had the highest depression scores. The 46-55-year-old SDW female clergy had higher depression scores.

## Discussion

The study established that over half of the clergy (52%) had depressive symptoms, which were statistically similar (p=.752) among the male (51.1%) and the female clergy (54.3%). The prevalence rate of 52% was similar to Omungo et al. (2020) study among older clergy in Nairobi, which found a similar prevalence rate at 52%. Machogu et al. (2022) on the other hand found a lower prevalence rate among fourteen priests in the deanery in Nairobi, at 28.5%. Solomon et al. (2020) study in Nigeria, among 84 Seventh-Day Adventist pastors, found a 19% prevalence (n=16), although the study utilized PHQ-9 as opposed to BDI-II, and hence, the disparities need further investigation.

The current study expected that females would have higher rates of depression in line with studies that show female preponderance to depressive episodes and depressive symptoms worldwide (Bromet et al., 2011; Ferrari et al., 2013; Salk et al., 2017; Shi et al., 2021; Van de Velde et al., 2010). This finding could thus imply that among this cohort, male clergy were experiencing stressors that heightened their depressive symptoms, which is probably an area requiring deeper investigations.

The study findings regarding the relationship between age and depression showed statistically significant higher depression prevalence among the younger clergy aged 26-35 years. This could be explained by the fact that developing internal coping mechanisms for difficult circumstances and obstacles in life is correlated with age; the older the pastor becomes, the more (and better) coping mechanisms they use (Büssing et al., 2017). Webb and Chase (2019) observed that age predicted a decrease in reported work distress. Likewise, Doolittle (2010) found that his study's younger clergy members had a higher likelihood of meeting the requirements for burnout. Results showed that older persons had greater adaptive reactions to everyday stressors than younger adults, further corroborating stress vulnerability in younger age (Schilling & Diehl, 2015).

Solomon et al. (2020) study also revealed a correlation between age and depression, which was attributed to the older being more experienced and stronger spiritually. Lau (2020) recommends better preparation for younger clergy for the demands of the occupation and implementing

policies to minimize exposure to occupational distress. It is thus possible that younger individuals within religious communities may face unique stressors or challenges that contribute to elevated levels of depressive symptoms. Some future studies scrutinizing this finding would be eye-opening.

The current study did not find statistically significant differences in the prevalence of depression based on marital status, but notably, depression prevalence was higher among the separated/divorced/widowed (S/D/W) (*n=5*; 71.4%) and those who were single (*n=9*; 64.3%). Thus, the majority of the S/D/W and single clergy were depressed. According to Andrade et al. (2003) epidemiological research, people who are separated or divorced have significantly higher rates of depression than those currently married. Further focusing on the interaction between the severity of depression based on marital status and age group for each gender, findings showed that for the female clergy, depression was more severe among the married 36-45-year-old clergy (M=26.5, SD=2.12), the 46-55-year-old separated, divorced, or widowed clergy (M=19.5, SD=13.43), while for males it was more severe among married 26-35-year-old (M=19.22). Thus, it seems that among the 26-35-year-olds, the noted high depression scores were mainly from the married male clergy, raising the question, *"Does getting married early among males lead to increased depression?"*

Other studies suggest that married female clergy in the 36–45-year age group may face various stressors. In this age group, there are both social, economic, and biological risk factors. As for the social risk factors, "Sociotropy" is defined as the tendency to overemphasize maintaining positive social relationships (Beck et al., 2021). Sociotropy consistently correlates positively with depression (Yang & Girgus, 2019). Consequently, Hochschild, (2012) states that women clergy may have sacrificed too much to profit from these social connections. They further state that studies on emotions in organizations show that women carry out more emotional labor than males. Thus, it is possible that female clergy members may be helping too many people, which could render their relationships pointless.

Silver (2024) states that the 40s and 50s are times when life's pressures can be greatest for women. All this stress can add to mental health challenges. Mitchell (2017) found that clergy, especially clergywomen, had a shared experience of stress and balancing various roles. For

instance, being a wife, mother, and minister can occasionally result in overburden. The experience of juggling multiple roles became even more intense, including that of mentor, caretaker, grandmother, advisor, and counselor. Conducting ministry in an area dominated by men required them to overcome obstacles like sexism, overcome difficulties like the stained-glass ceiling, and manage many roles while preserving their general health and well-being (Hutchinson, 2019).

LeGrand et al. (2013) state that a situation where men occupy the majority of influential decision-making roles may encourage women to stand as a unit. However, openness may not always result from solidarity because women may not feel as comfortable talking honestly about their emotional issues for fear of appearing weak in front of their female coworkers, with whom they fight for comparatively fewer possibilities. Evidence from an analysis of a focus group of female pastors supports this; it showed that the women pastors were reluctant to talk about their challenges with other female clergy members because they did not want to seem weak in a field that men dominate. Women clergy may place much pressure on themselves to be models of virtue, preventing them from getting the help they need.

Kulkarni (2018) additionally enlightens that some of the biological factors within this age group are perimenopausal depression symptoms, which can fluctuate in severity, thus adding to the diagnostic difficulty. Some of the symptoms of perimenopausal depression and, in particular, the cognitive symptoms, such as paranoia and irritability, are marked in perimenopausal depression compared to symptoms of major depressive disorders seen in men or younger women (Kulkarni, 2018). Additionally, women between 36 and 45 years of age face increased family burdens, such as juggling work with raising kids, while others have to contend with postpartum depression after giving birth or having a miscarriage, which may exacerbate the depression (Handing et al., 2022). Hence, targeted psychological interventions for this cohort are critical.

Thus, it is possible that young clergy, at the beginning of their careers, encounter challenges that may predispose them to depression, and also the older clergy who have served for long. Furthermore, the unique challenges posed by gender and marital status must be considered in understanding factors associated with mental health outcomes among clergy, as they can inform intervention programs. This is also supported in other studies, such as the Yan et al. (2011)

study, which revealed that individuals who were widowed, divorced, or unmarried were more likely to experience depressive symptoms. For females, being separated, divorced, or widowed is probably an indicator of having faced various challenges in life, shattered dreams, and loss, which can lead to depression. Edwards et al. (2022) found that a lack of perceived social support and lower levels of spiritual well-being may contribute to the elevated rates of depression among clergies.

These findings have important implications for mental health interventions and support programs targeting clergy members. They highlight the need for tailored approaches to address different sociodemographic characteristics' specific needs and challenges. By understanding the factors contributing to depression prevalence among clergy members, healthcare professionals and religious institutions can develop more effective strategies to promote clergy well-being and enhance mental health outcomes within this population.

## Conclusion

The study found that 52% of clergy had depressive symptoms, with similar rates among males (51.1%) and females (54.3%). Younger clergy, aged 26-35, were more affected. This maybe due to their limited coping mechanisms while older clergy demonstrated greater resilience. Overall, marital status did not significantly affect depression rates, but higher levels were observed among separated, divorced and widowed clergy. The female clergy, especially those aged 36-45, experienced higher levels of depression, and thus a qualitative study is recommended to highlight predisposing factors.

The study also highlighted the need for tailored mental health interventions for clergy, considering gender, age, and marital status. Younger clergy and women, especially those balancing multiple roles or facing significant life transitions, require targeted support. The understanding of these sociodemographic factors is crucial for developing effective mental health strategies for clergy well-being.

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