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RESEARCH ARTICLE

The Relationship between Lutheran Pastors' Well-Being and Depression and the Professional Support Available to Them: A Quantitative Study in the Hungarian Lutheran Church

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Introduction: Several studies confirm the unfavorable physical and mental health status of church pastors. These findings have often been linked to the level of social support they receive.
Aims: The purpose of this study is to provide insights into the relationship between the mental health of Hungarian Lutheran pastors and the availability of professional support. We examined which form of support shows the strongest association with their well-being and depression.
Methods: The quantitative research was conducted in 2022 in the Hungarian Lutheran Church. 54.0% of pastors (N = 148) completed the survey. Mental health status was measured using the WHO-5 Well-Being Index (WBI-5) and the 9-item Beck Depression Inventory (BDI). Three kinds of professional support were measured in the questionnaire: supervision, spiritual direction, and peer group support.
Results: The results clearly indicate a significant association between increasing levels of support utilized by pastors and improved well-being [χ^2 (3, N = 139) = 28.75, p < .001]. In the binary logistic regression analysis, the odds of being classified in the non-normal category of the BDI decreased by approximately 60.0% if pastors had a supervisor or spiritual director [χ^2 (3, N = 132) = 15.33, p = .002, Nagelkerke R^2 = 15.1%].
Conclusions: Our results suggest that professional support has a stronger association with pastors' mental health status than any socio-demographic characteristics. The authors conclude that it is important to establish professional support systems for clergy to strengthen their ministry within the Hungarian Lutheran Church.

Keywords: clergy, professional support, well-being, depression, Lutheran

Introduction

There are several current challenges facing church pastors that put them at risk of poor health. These include changes in societal norms, difficulties related to an aging population, the prevalence of social media and online activities (Kapus et al., 2021), urbanization, and increasing mobility (Dyson, 2011). These challenges also affect the developed world, including Hungarian society, exerting pressure on families, churches, and small communities. Church pastors find themselves at the intersection of these domains, grappling with these issues both in their communities and personal lives. In facing these challenges, they are often left on their own, without support,

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which can lead to isolation. However, professional support can help them cope more effectively and improve their mental state (Eagle et al., 2018). Therefore, this article addresses the relationship between the well-being and the depression of pastors and three forms of professional support.

The Well-Being of Pastors

Well-being is a multi-level concept and a subject of ongoing professional debate (La Placa et al., 2013). In the case of pastors, it can be formulated through the following dimensions: happiness, a capacity for higher level of resilience, flourishing, or positive self-sacrifice linked to one's calling (Adams & Bloom, 2017). All these dimenions are closely linked to physical and emotional health.

Numerous studies indicate that pastors are a risk group regarding health issues. They tend to have poorer physical health (e.g., obesity and related diseases) and mental health indicators than the general population, although they often self-report better health than what measured data indicate (Proeschold-Bell & LeGrand, 2010; Weems & Arnold, 2009). The challenges of being a pastor caused a high level of stress with multiple underlying factors (Chan & Chen, 2019). External factors such as the conditions of service (Brewster, 2012), years spent in ministry (Járay & Siba, 2024), family stressors (Hill & Raimondi, 2003), internal factors such as role ambiguity (Faucett et al., 2012), and coping strategies (Mazzarella, 2010) contribute to the poor outcomes.

A growing body of research is focusing on both positive and destructive coping strategies that increase or decrease resilience (Doolittle, 2007). On the one hand, destructive coping strategies are present, such as sexual addictions (Ahmad et al., 2015) and emotional eating (Manister & Gigliotti, 2016). On the other hand, intrapersonal spiritual coping strategies, such as prayer or meditation, are primary resources that clergy rely on to deal with stress (Turton & Francis, 2007).

The Context and Characteristics of Social Support and Social Networks of Pastors

Social support plays a key role in maintaining health. Several studies confirm that individuals with severe illnesses who receive higher levels of peer support have a 50.0% higher likelihood of survival in old age (Heffner et al., 2011) as well as a significantly lower risk of various cardiovascular diseases (Tay et al., 2012). Conversely, a lack of peer support and isolation have been associated with negative health outcomes, including obesity, hypertension, diabetes, anxiety, and depression (Bland et al., 1991; DeJoy et al., 2008).

There is also a correlation between social support, mental health, and clinical indicators such as depression (Harandi et al., 2017; Sacco & Yanover, 2006). It has long been confirmed that social support from one's family, church congregation, or the wider community has a positive influence in the lives of pastors (McMinn et al., 2005). However, social isolation is one of the most significant stressors for pastors in their ministry (Stuart-White et al., 2018). The lack of social connection and support, as well as feelings of loneliness and isolation, are strongly linked with pastors' motivation to leave the profession (Hoge & Wenger, 2005).

A systematic review found that there is a stronger interaction between social support and depression among pastors than in the general population (Edwards et al., 2020). While the relationships between received support and mental health outcomes are relatively weak, the correlation with perceived social support is notably strong (Lakey & Cronin, 2008). Research shows that among pastors, perceived social support is a greater determinant of mental health than the quantity and quality of support actually received (Eagle, 2018).

Pastors tend to experience the joy and power of personal relationships in their supportive roles. However, they also experience less reciprocity in support, which can be of great importance (Buunk et al., 1993). Frequent relocations due to ministry, distance from one's place of origin, and the responsibility of managing multiple communities can lead to the weakening - or, in extreme cases, the complete dissolution - of personal social networks and important existing relationships. As a result, when pastors seek interpersonal support, it is more likely to be from their spouses or family members rather than from other external sources of support (Hill & McWey, 2004).

In Central and Eastern Europe, seeking support from family has historical roots, since under communism, even trusting fellow congregants could be risky. This is one reason why the immediate family has traditionally become one of the most important sources of support in the challenges of the pastoral vocation. However, this can be challenging, as clergy families also suffer from the same effects (Hill & Raimondi, 2003), which can further increase stress and erode the support they provide to each other. This can lead to social distance between clergy families, other families, or communities (Morris & Blanton, 1994). All these factors can easily lead to the isolation of clergy (Muskett & Village, 2016). Thus, the need for additional external help to support the vocation is both justified and meaningful.

Professional Help in Ministry

Researchers have explored many aspects of burnout and professional support, including its relationship with psychological well-being and service satisfaction (Morrow et al., 2021). The vast majority of these studies show a connection between higher levels of psychological well-being, lower levels of stress, and the receipt of professional support (Francis et al., 2013). Professional support has been shown to be one of the most effective resources for maintaining psychological well-being. Chaplains recognize the need for professional support and mentoring (Brown-Bennett, 2017), however, there are several factors that can make accessing this support difficult (Pietkiewicz & Bachryj, 2016). These include feelings of shame, lack of trust, and fear of organizational retaliation. A pastor who lacks these forms of support, whether due to external or internal reasons, is more likely to experience poorer mental health (Doolittle, 2007). Fortunately, there are several forms of professional support that pastors have developed for themselves. Here, we focus on the two most common: peer support group and one-on-one support (e.g., mentoring, supervising, and spiritual direction).

Peer support groups

Peer support groups among clergy represent one of the most prominent forms of support. These can be moderately supportive for pastors, yet weakly beneficial in lowering psychological distress (Miles & Proeschold-Bell, 2013). However, a supportive peer group can reduce both the feelings and effects of isolation (Staley, 2012). Investigations by Marler et al. (2013) determined the qualities of a 'good' peer group. In their study of 31 different pastoral peer groups, they found that sharing personal concerns, enjoying fellowship, receiving feedback on ministry, and praying for one another were the most supportive key practices. Support groups for pastors provide a unique opportunity to express themselves, be heard, feel understood, and receive feedback without being judged by others (Marler et al., 2013). Oswald (2005) highlights five important benefits a peer group can offer: holding, protection, confrontation, authentication, and perspective. A friend who is not a pastor may struggle to grasp the complexity of pastoral challenges due to differing life experiences. Even a pastor's spouse is often unable to provide complex understanding and support due to her own involvement in the ministry and church community. Pastors benefit from the fraternity they find in one another and outside their ministry and family contexts.

One-on-one support: Mentors, supervisors, spiritual directors

Another form of meaningful professional support for clergy is one-to-one relational support from those who help pastors with their individual issues (e.g., professional and personal issues or their relationship with God). This type of support can be effective in areas such as clergy mentoring (Brannagan, 1998) and burnout (Doolittle, 2008). At the same time, Baugess (2002) notes that it is methodologically difficult to establish clear connections between good mental health status and one-on-one professional support, as pastors often turn to personal, professional help after experiencing burnout. Nonetheless, having a mentor seems to improve mental health functioning compared relying solely on family support. Those with a partner and a mentor have higher Ego-Resiliency scores than those who have a partner but no mentor (Clarke et al., 2022). A supportive supervisory relationship also increases pastors' subjective sense of well-being (Gubi et al., 2023). In some studies, professional supervision was shown to correlate with greater job satisfaction and better overall well-being (Proeschold-Bell et al., 2015). In Protestant traditions, spiritual direction has been a less widespread form of support for clergy (Whitlock, 2002). However, research shows a strong correlation between spiritual dryness and poor well-being (Büssing et al., 2013). Spiritual programs, retreats, and resources have become increasingly popular as ways of supporting pastors. Moreover, their beneficial effects are often quickly felt (Ellison et al., 2009).

Aims

As there has been no comprehensive research to date on the well-being and health status of Lutheran pastors, not only in Hungary but also in the whole Central European region, the focus of our research was to provide an overall picture of the Hungarian Lutheran clergy, including measures of their physical health, mental health status, social support, and how these factors relate to their sociodemographic characteristics and church careers. The article focuses on the association between professional support (from a supervisor, spiritual director, or peer support group) and mental health status, as measured by well-being and depression.

The Hungarian Lutheran church is one of the smallest historical Christian denominations in Hungary. It has a

total membership of 176,503, approximately 1.8% of the Hungarian population. Although this distribution reflects the religious history of the country, Lutherans are overrepresented in certain settlements and regions, which are often geographically distant from one another.

In the Hungarian Lutheran church, there is no centrally organized system of personal nor professional support for pastors. Most pastors must seek professional help on their own. Although professional support can take several different forms, our research focuses on the three most common among lutheran pastors: the availability of supervisor support, a spiritual director, and a peer support group.

We hypothesized that all three forms of professional support would be positively related to well-being and negatively related to depression. This article seeks to answer the following two research questions:

1. What is the status of well-being and the level of depression among Hungarian Lutheran clergy?
2. What types of professional support are associated with well-being and depression?

The purpose of this investigation was to understand the significance of these forms of professional support and to serve as a basis for future interventions aimed at developing a more effective support system for clergy in the Hungarian Lutheran Church.

Methods

Participants

There were 284 Hungarian Lutheran pastors actively serving in ministry at the time of data collection in 2022. We excluded retired pastors and theology students in seminary; only those currently employed by the Church as pastors, regardless of their area of ministry, were included in the study. A total of 148 pastors completed the survey, which corresponds to a 52.0% completion rate within the entire Hungarian target population. This is considered a high response rate for clergy surveys. Since answers were optional for individual questions, not all socio-demographic items were answered by every participant. Some respondents viewed this as a way to ensure anonymity. Regarding age, the sample was divided into five broad categories, reflecting both spent time in ministry and life stage. In creating the categories, we consulted Lutheran pastors and professionals working with them. The socio-demographic characteristics of the sample are presented in Table 1.

Table 1. Socio-demographic characteristics of the sample

Characteristic				
Age average	45.7 (*Mdn* = 46, *SD* = 9.39, *Min* = 26, *Max* = 66)			
Age groups	*N*	%	CI (95%) lower	CI (95%) upper
24–33	18	12.2	7.64	18.14
34–40	28	18.9	13.25	25.82
41–49	48	32.4	25.33	40.28
50–55	30	20.3	14.38	27.39
56+	24	16.2	11.02	22.83
Sex	*N*	%	CI (95%) lower	CI (95%) upper
Males	84	56.8	48.75	51.27
Females	64	43.2	35.55	64.49
Marital status	*N*	%	CI (95%) lower	CI (95%) upper
single	9	6.2	3.12	10.77
married	121	81.8	75.03	87.31
divorced	18	12.1	7.60	18.18
Number of children	*N*	%	CI (95%) lower	CI (95%) upper
no child	17	11.5	7.19	14.73
one child	21	14.2	9.29	20.51
two children	34	23.0	16.81	30.17
three children	44	29.7	22.81	37.39
four or more children	32	21.6	15.56	28.82

Table 1. continued

(continued on the next page)

Characteristic				
Age average	45.7 (*Mdn* = 46, *SD* = 9.39, *Min* = 26, *Max* = 66)			
Settlement type of the ministry	*N*	%	CI (95%) lower	CI (95%) upper
village	44	29.9	23.05	37.70
small town	41	27.9	21.08	35.54
big city	30	20.4	14.52	27.51
capital	32	21.8	15.70	28.87
Type of church ministry (more choice was allowed)	*N*	%	CI (95%) lower	CI (95%) upper
parochial pastor	104	70.3	62.69	77.28
associate pastor	8	5.4	2.57	9.91
assigned pastor	10	6.8	3.56	11.72
institutional chaplain	26	17.6	12.08	24.34
other position	30	20.3	14.42	27.27

Procedure

The data collection took place between May 11, 2022 and June 8, 2022 using an online data collection method. All active Hungarian Lutheran clergy at the time of research (N = 284) were invited via e-mail to participate in an anonymous survey and received at least three reminder messages. The letters of invitation were sent to the clergy by representatives of the dioceses concerned. Limesurvey software was used to carry out the data collection. The data were saved only after participants agreed to submit their answers. Participants were required to confirm their consent by ticking a check box' in a consent form, indicating their agreement to take part in the study prior to completing the questions. The average completion time was 45 minutes. Participants were informed of the ethical reference number and reminded that participation was voluntary. Ethical approval was obtained from the Hungarian Scientific and Research Ethics Committee, ETT TUKEB Reference Number: BM/11885-3/2023/EKU.

Measures

The questionnaire administered to Hungarian Lutheran pastors consisted of five sections: basic demographic data, information about their work and career, physical health, mental health, and social support. In choosing the survey instruments, we aimed to use questionnaires that have been used in large, representative Hungarian sample to enable comparison with our results. In our analysis, we used similar variables and categories to those used in the Hungarostudy 2021 (KINCS, 2022). For both age and mental health measures, previous analyses conducted with continuous variables yielded similar results.

WHO-5 Well-Being Index (WBI-5; Staehr, 1998; Susánszky et al., 2006)

The WHO-5 Well-Being Index is used to measure subjective psychological well-being as an indicator of mental health and has demonstrated high clinimetric validity (Topp et al., 2015). The measure is used both as a continuous and as a categorical variable. For the sake of comparability with the nationally representative Hungarian sample, we used it as a dichotomous variable in our analyses. In addition, the aim of the research was to provide church leaders with an understanding of the number and characteristics of individuals at risk, based on clinical classifications. The Hungarian version of the WHO-5 Well-Being Index (Cronbach's alpha = .85) contains the same questions as the original version, but the responses are scored on a 0 to 3 scale (0 = at no time; 3 = all the time). The validated Hungarian WHO-5 index is interpreted in the range of 0–15. On the standardized Hungarian scale for the nationally representative sample, the cut-off point between the top and bottom 50% is between 7 and 8. We used the same cut-off point in our analysis: the score range for the bottom 50% (i.e., the risk category) is 0–7, while the range for the top 50% (i.e., the normal level category) is 8–15. The instrument also demonstrated reliability (Cronbach's alpha = .77) in our sample.

The 9-item Beck Depression Inventory (BDI-H; Kopp et al., 1997; Rózsa et al., 2001)

The Beck Depression Inventory was also used as an indicator of mental health in the Hungarian sample. The nine-item shortened version, previously piloted in Hungary, was used in the present study (Rózsa et al., 2001). Each item has four response options (1 = absolutely typical; 2 = typical; 3 = hardly typical; 4 = not at all typical). In the Hungarian validation study, the items demonstrate good internal consistency (Cronbach's alpha = .83). This scale was also analysed as a categorical variable for the reasons mentioned above. The items were reversed according to international standards. There are four categories based on the BDI scores: 0–9 points indicate 'no depressive symptoms', which is considered a 'normal' status; 10–18 points indicate 'mild' symptoms; 19–25 indicate 'moderate'; and scores above 25 points indicate 'severe' depressive symptoms (Kopp et al., 1997). During the analysis, we only examined the difference between two broader categories: 'normal' (0–9 points) and 'at risk for some level of depression' (values above 9 points). In our sample, the Cronbach's alpha coefficient was .75.

Professional Support

The average clergy who are not trained in this area often uses a variety of terms to refer to their professional supporters, such as mentor, supervisor, pastoral care, or spiritual father. The question aimed to clarify the nature of support. In the section related to their professional status, we asked three questions and their sub-questions: 'Do you have a person who supports you with regular advice related to your ministry?' (supervisor); 'Do you have a spiritual director, someone you can talk to about your personal relationship to God?' (spiritual director); and 'Do you participate in any pastors' group that meets regularly and are designed to support your personal vocation and ministry?' (peer support group). If they responded 'no', they were asked whether they would like to have such a person? If they responded 'yes', a follow-up question asked how many times did they had met over the past year. The following response options included once, 1–2 times, 3–5 times, monthly, several times a month, and 'we haven't met in the past year'. Only support relationships that involved at least once during the previous year were taken into account.

Statistical Analysis

We calculated descriptive statistics, including means, ratios, and confidence intervals. In our analysis, we used crosstabulation with chi-square statistics to compare pastors with and without professional support in terms of depression and well-being. Thirdly, we performed multivariate analyses with binary logistic regression models (i.e., chi-square and odds ratio) to examine the relationship between the professional support and the likelihood of being in the WHO-5 Well-Being risk category or the Beck Depression Inventory 'risk for some level of depression category' category. The analysis was conducted using IBM SPSS Statistics 28.0.1.0.

Results

Some of the mental health indicators measured in our sample were compared with the results of the Hungarostudy 2021, a large, nationally representative survey conducted Hungary (KINCS, 2022). Since one of our co-authors was involved in the analysis of that study, we had the opportunity to use a sample featuring similar age and education level data from the Hungarostudy population for the purposes of comparison.

Mental Health Condition

The Hungarian Lutheran clergy in our sample showed relatively poor mental health indicators compared to the nationally representative Hungarostudy 2021 sample (KINCS, 2022; Table 2.). 29.5% of the Lutheran pastors fell into the WHO-5 Well-Being risk category, whereas only 14.4% of the general Hungarian population in the Hungarostudy sample were in the same category [χ^2 (1, N = 139) = 27.72, p < .001]. A similar difference was observed for depression. 35.3% of pastors were classified in the 'risk for some level of depression' category in the BDI-H scale. In comparison, only 25.0% of the Hungarostudy sample indicated some level of depression [χ^2 (1, N = 139) = 7.79, p = .005]. At the same time, fewer pastors were classified in the severe depression category (1.4%) compared to the sample representing the Hungarian population as a whole (11.0%) [χ^2 (1, N = 139) = 12.98, p < .001] (KINCS, 2022).

Table 2. Well-being (WBI-5) and depression (BDI-H) charctaristics of the Hungarian Lutheran Pastors

Characteristic				
WBI–5 (*N* = 139)	8.6 (*Mdn* = 9.0, *SD* = 2.55, *Min* = 2, *Max* = 15)			
WHO categories	*N*	%	CI (95%) lower	CI (95%) upper
normal	98	70.5	62.62	78.39
risk	41	29.5	21.56	37.42
BDI-H (*N* = 139)	8.7 (*Mdn* = 6.6, *SD* = 9.39, *Min* = 0, *Max* = 29)			
Beck depression categories	*N*	%	CI (95%) lower	CI (95%) upper
normal	90	64.7	56.81	72.73
mild	30	21.6	15.08	28.10
moderate	17	12.3	7.24	18.02
severe	2	1.4	0.00	3.60

None of the sociodemographic variables showed significant differences regarding 'risk' status on the WBI-5 scale. This includes gender [χ^2 (1, N = 142) = .87, p = .351], settlement type [χ^2 (1, N = 142) = .71, p = .400], and age group [χ^2 (4, N = 142) = 4.22, p = .377].

In the case of depression, the only significant difference among these variables was related to settlement type. While the difference is not significant based on the cross tabulation analysis by all settlement type [χ^2 (3, N = 143) = 5.94, p = .114], adjusted residual analysis justified merging the groups of pastors based on settlement type. The proportion of pastors serving in the capital was significantly lower in the depressed categories (17.2%, N = 45) compared to the merged category of pastors serving in other locations [39.5%, N = 45, (χ^2 (1, N = 143) = 5.03, p = .025].

Professional Support and Mental Health

Professional support appears particularly important in light of the above results which, as expected, indicate mental health risks among the clergy. First, we examined whether there is an association between the three types of professional support (supervision, peer support group, spiritual direction) and mental health status (subjective psychological well-being and depression). Based on the availability of various kinds of professional support, we created four groups: (0) those who reported no professional support at all, (1) those who reported only a single type of professional support, (2) those who reported at least two types of professional support in their lives, and (3) those who reported having all three types of professional support (Table 3).

Table 3. Frequencies of professional support

Pastors who received professional support in the last year	*N*	%	CI (95%) lower	CI (95%) upper
have a supervisor	75	54.7	46.04	63.48
have a spiritual director	44	32.1	24.08	40.91
part of peer support group of pastors	80	54.8	46.57	62.33
Number of professional support types reported	*N*	%	CI (95%) lower	CI (95%) upper
0	26	17.6	12.11	24.29
1	63	42.6	34.75	50.65
2	36	24.3	18.02	31.75
3	23	15.5	10.44	22.04

Figure 1. The percentage of pastors in the well-being risk category by the number of support types reported among the Hungarian Lutheran clergy

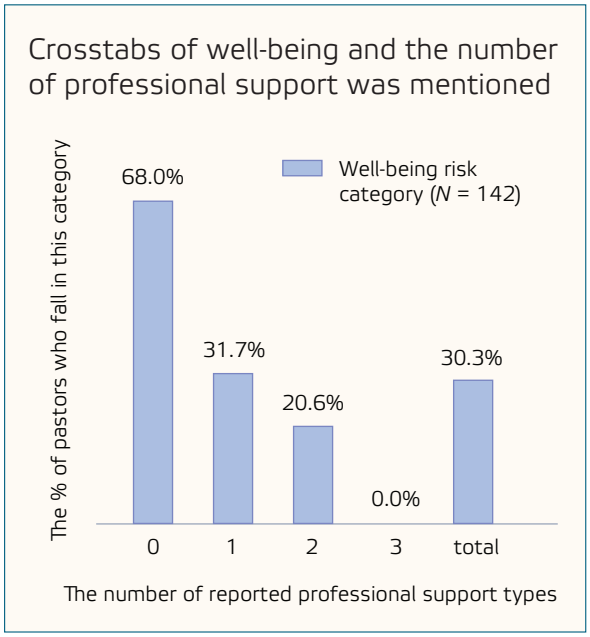
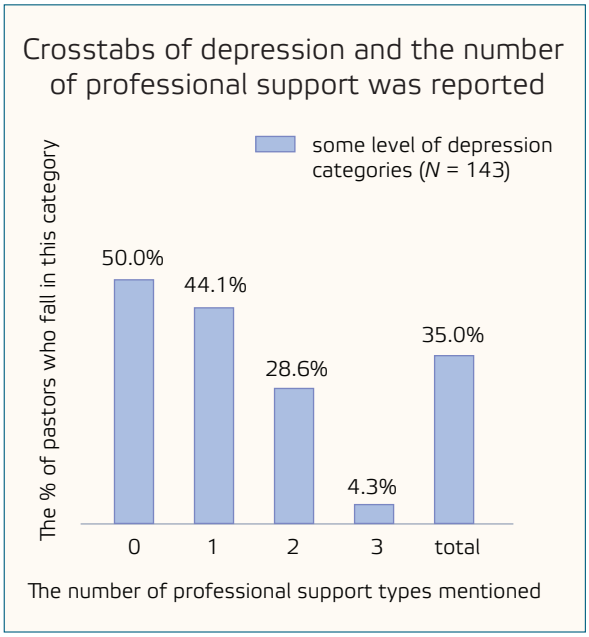


Figure 2. The percentage of pastors being in some level of depression category by the number of support types reported among the Hungarian Lutheran clergy



There is a positive association between the number of support types and pastors' well-being. The more types of support pastors use, the better their mental health conditions [χ^2 (3, N = 142) = 28.40, p < .001] (Figure 1).

The relationship between the availability of professional support and pastors' depression levels were also analyzed. Pastors who reported a greater number of support types were less likely to fall into the depressed categories (Figure 2). The results here were statistically significant, χ^2 (3, N = 143) = 14.85, p = .002. This indicates that, in our sample, the availability of professional support has a positive association with mental health.

WBI-5 and different types of professional support

Binary logistic regression models were used to investigate whether there is a relationship between being in the risk group according to the WHO-5 Well-Being Index and the three types of professional support: supervision, spiritual direction, and peer support groups. The analysis was conducted by examining the effects of each factor separately and then together. Individually, each of the support factors were significant in the models *(Tables in Appendix):* Model 1: Supervisior [χ^2 (1, N = 137) = 18.79, p < .001, Nagelkerke R^2 = 18.2%, OR = 0.18]; Model 2: Spiritual director [χ^2 (1, N = 137) = 7.77, p = .005, Nagelkerke R^2 = 7.7%, OR = 0.30]; Model 3: Peer support group [χ^2 (1, N = 140) = 10.96, p < .001, Nagelkerke R^2 = 10.6%, OR = 0.29]; in the case of the combined model [χ^2 (3, N = 131) = 35.21, p < .001, Nagelkerke R^2 = 33.1%, OR = 0.62], when controlling for the presence of other forms of support, the effect of the spiritual director was no longer significant.

The analysis yielded an odd ratio (OR) of 0.18 for having a supervisor, with a 95% confidence interval (CI) of [0.08, 0.41], p < .001, when not controlling for other forms of support (Model 1), and an odds ratio (OR) of 0.14 for having a supervisor, with a 95% confidence interval (CI) of [0.54, 0.36], p < .001, when controlling for the other support types (Combined model). This indicates that pastors with a supervisor are five times less likely to fall into the well-being risk group, even when the effects of having a spiritual director and peer support group are accounted for in the model. This suggests that the effect of having a supervisor is somewhat independent from the effects of spiritual directors and peer support.

Similarly, the analysis yielded an odds ratio (OR) of 0.30 for having a spiritual director, with a 95% confidence interval (CI) of [0.12, 0.74], p < .01, when not controlling for other forms of support (Model 2), and an odds ratio (OR) of 0.62 for having a spiritual director, with a 95% confidence interval (CI) of [0.22, 1.80], p = .380, when controlling for the presence of other support forms (Combined model). This indicates pastors with a spiritual director are 70% less likely to fall into the well-being risk group when considered individually. However,

this relationship is no longer statistically significant when the effects of supervisors and peer support groups are accounted for in the model.

In the case of peer support group, the analysis yielded an odds ratio *(OR)* of 0.29 for being a member of such a group, with a 95% confidence interval (CI) of [0.14, 0.61], $p < .001$, when not controlling for other support forms (Model 3), and an odds ratio (*OR*) of 0.19 for participating in such a group, with a 95% confidence interval (CI) of [0.08, 0.48], $p < .001$ when controlling for other support forms (Combined model). This indicates that pastors who are members of peer support groups are approximatly 70% less likely to fall into the well-being risk group; this effect is even more pronounced when considered alongside the presence of spiritual directors and supervisors.

BDI-H and different types of professional support

The Beck Depression Inventory measures different characteristics of mental health (specifically, depressed mood). Compared to well-being, the three types of professional support have different links with depression level.

Binary logistic regression models were also used to investigate whether there is a relationship between non-normal levels of depression evaluated by the Beck Depression Inventory and the three different types of professional support. In the case of depression, results differed slightly compared to well-being. The procedure followed was identical to that used in investigating the relationship between the WHO-5 Well-Being Index and the three different kinds of professional support. The effects of each factor were examined together and then separately (See tables in Appendix).

The combined model was statistically significant [χ^2 (3, $N = 132$)= 15.33, $p = .002$, Nagelkerke $R^2 = 15.1\%$]. Model 1: Supervision [χ^2 (1, $N = 138$) = 7.86, $p = .006$, Nagelkerke $R^2 = 7.6\%$, $OR = 0.36$]; Model 2: Spiritual direction [χ^2 (1, $N = 138$) = 9.80, $p = .002$, Nagelkerke $R^2 = 9.4\%$, $OR = 0.27$]; Model 3: Peer support group [χ^2 (1, $N = 141$) = 3.06, $p < .09$, Nagelkerke $R^2 = 2.9\%$, $OR = 0.54$]. In our sample, participation in a peer support group had no significant effect on depression. However, the other two support forms proved significant in both in the combined model and individually.

The binary logistic analysis for the depression levels measured by the BDI yielded an odds ratio (*OR*) of 0.36 for having a supervisor, with a 95% confidence interval (CI) of [0.18, 0.74], $p = .006$, when not controlling for the other support types (Model 1); the analysis yielded an odds ratio (*OR*) of 0.44 for having a supervisor, with a 95% confidence interval (CI) of [0.20, 0.95], $p = .037$ when controlling for the other support forms (Combined model). This indicates that pastors with a supervisor showed a one in three chance of falling into the BDI's non-normal depression category, even accounting for the presence of spiritual directors and peer support groups in the model.

Regarding the presence of a spiritual director, the analysis yielded an odds ratio (*OR*) of 0.27 for having a spiritual director, with a 95% confidence interval (CI) of [0.12, 0.65], $p = .004$, when not controlling for other support types (Model 2), and an odds ratio (*OR*) of 0.39 for having a spiritual director, with a 95% confidence interval (CI) of [0.16, 0.99], $p = .050$, when controlling for the presence of other support forms (Combined model). This indicates that not having a spiritual director increases the risk of falling into the BDI's non-normal depression category approximately fourfold, even when the presence of supervisors and peer support groups are taken into account in the model.

Lastly, the effect of a peer support groups was not detected in any of the binary logistic regression models for BDI depression levels. None of the parameters reached significance, neither for the combined model [$OR = 0.52$ with a 95% confidence interval (CI) of [0.24, 1.12], $p = .090$] nor separately [Model 3: $OR = 0.54$ with a 95% confidence interval (CI) of [0.27, 1.08], $p = .080$]. This may be due to the low sample size and the fact that only a small group of pastors reported very poor mental health.

Discussion

Our results confirmed previous research indicating that clergy have worse mental health indicators than the general population (Proeschold-Bell & LeGrand, 2010). Overall, this study of the Hungarian Lutheran clergy found that a significant proportion reported mental health issues. 29.5% of them fell into the risk category of the WBI-5 Well-Being Index, and 35.3% reported non-normal level of depression according to the Beck Depression Inventory. Only one association was found among the sociodemographic factors: pastors serving in the capital showed greater

protection in terms of mental health. The main reason for this may be that they are able to serve in larger communities, which may increase satisfaction with their ministry. This in turn may have a strong impact on their mental health (Shehan et al., 2007). Another possible explanation may be that pastors living in larger settlements have greater access to support networks and experience lower levels of isolation (Francis et al., 2015), highlighting that social support is closely linked to mental health.

Professional Support and Well-Being

This study aimed to understand how professional support, as a special form of social support, is linked to mental health. Mental health was operationalized using two internationally well-established and locally widely used indicators: the WHO-5 Well-Being Index and the 9-item Beck Depression Inventory. In our results, it is clear that these types of support have existing links to mental health. The results suggest that the more sources of professional support pastors have, the higher their reported well-being. However, there are differences between the effect sizes. In our sample, having a personal supervisor showed the strongest link with better well-being. The availability of peer group support was also positively linked with well-being. While in a separate model the presence of a spiritual director has a statistically significant positive association with the WBI-5, its effect was no longer detectable in the combined model. One possible explanation is that in the Lutheran context, spiritual direction is not a well-known, widespread form of support. Despite the focus of this support being clearly described in the relevant questionnaire item, some respondents may have confused it with supervision, referring to the same person with whom they discuss both professional and faith issues.

Professional Support and Depression

Similar results are only partially observed for associations with depression. The analysis showed that pastors who reported having a supervisor or spiritual director were less likely to suffer from some level of depression. However, the same association with peer group support could not be statistically confirmed. With regard to support groups, there may be several reasons for this result. Firstly, certain levels of depression can impair social function. Although a pastor may continue to participate in a collegial group, they may no longer perceive its supportive nature. Another reason may be that often these groups function as preventive resources; when a pastor faces more severe struggles, the peer group may no longer provide sufficient support. Often, these pastors withdraw from the group. It is also clear that the two 'one-to-one' support types, supervision and spiritual direction, show a weaker association with depression compared to well-being. This may be due to the fact that more serious psychological issues require more specialized help and, where appropriate, therapy. In such cases, supervisors or spiritual directors may not be able to provide adequate care, and the pastor should be referred to a professional mental health specialist.

Overall, similarly to the results of previous research (Baugess, 2002; Brannagan, 1998; Miles, 2013), our results suggest that both professional and peer support may have significant roles in prevention and in supporting pastors in their struggles. Sufficient and varied support can help clergy to carry out their ministry in ways that preserve their well-being and mental health.

Strenghts and Limitations

One of this study's main strengths is that it represents the first comprehensive study on the general condition and mental health of pastors in the Hungarian Lutheran Church, clearly demonstrating the association between mental health indices and the availability of various support types.

Although we aimed to gather data from the entire population of Hungarian Lutheran pastors, building trust took time, and not all invited persons filled in the survey. As a result, the final database may differ from the characteristics of the overall population due potential response bias. A further limitation stems from the fact that the church administration was unable to provide us with characteristics of the total population. In the absence of such data, it was not possible to assess the resulting differences, nor was it possible to apply statistical weighting to the data.

Although the fact that approximately half of all pastors filled in the questionnaire represents a relatively high percentage within the church, the sample is too small for more complex statistical analyses, which could have

yielded further significant results (Bujang et al., 2018). Furthermore, it would have been beneficial to measure mental health with a broader range of instruments, but the time available for the questionnaire set limits to such endeavors.

In the analysis, we worked with several variables that could be analysed both as continuous and categorical. However, in several cases, the lack of a normal distribution limited the applicability of certain types of analysis.

Conclusion, Implications, and Future Directions

The aim of this research was to gain an overview of the current situation of Hungarian Lutheran clergy, serving as a foundation for the development of effective interventions, as church pastors are affected by multiple factors that pose health risks. The analyses presented offer insights into the relationship between the availability of professional support and the mental health status of Hungarian Lutheran pastors, indicating which forms of support show the strongest associations with well-being and depression. The results underscore the below-average mental health status of the clergy and its connection to the extent of available professional support. These findings may serve as a compelling argument for institutional changes and the expansion of such services in the Lutheran Church. For pastors, organizing their own professional support may serve as a practical step toward improving their well-being. This survey was the first milestone in an ongoing assessment process, with the direct goal of providing resources needed for the clergy to flourish both in their personal and professional lives and reduce attrition from the vocation.

Church leadership has already launched a number of support programs in response to the results of this survey. We also plan to initiate a longitudinal study to measure the long-term effectiveness of such interventions. Additionally, we seek to replicate this research among pastors of other denominations. Drawing from the Lutheran experience, new questionnaires have been developed and research continues on a larger sample in the Hungarian Reformed Church.

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Declaration of interest statement
The authors have no conflicts of interest to disclose.

Ethical statement
This manuscript is the authors' original work.
All participants engaged in the research voluntarily and anonymously.
Their data are stored in coded materials and databases without perso-nal data.
The studies involving human participants were reviewed and approved by Hungarian Scientific and Research Ethics Committee, ETT TUKEB, reference number: BM/11885-3/2023/EKU.

Data availability statement
To ensure anonimity and confidentiality, the Council of Bishops granted permission for the research on the condition that the database be managed by the researchers alone.

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Appendix

Binary logistic regression models parameters

Combined model – WBI-5 and professional supports [χ^2 (3, N = 131) = 35.21, p < .001, Nagelkerke R^2 = 33.1%]

Combined model (WBI-5 'risk' group)

	B	SE	Wald	df	p	Exp(B)	95% CI for Exp(B)	
							Lower	Upper
Are you part of a group of pastors, wich meets regularly for supporting the members? (Reference: take part in a peer support group)	-1.65	0.47	12.43	1	.000	0.19	0.08	0.48
Do you have a spiritual director who meets you regularly, and support you in your personal relationship to God? (Reference: have a spiritual director)	-0.47	0.54	0.77	1	.381	0.62	0.22	1.80
Do you have a person, who supports you with regular advice connecting to your ministry? (Reference: have a suprvisor)	-1.96	0.48	16.40	1	.000	0.14	0.05	0.36
Constant	1.08	0.41	7.01	1	.008	2.94		

Model 1 – WBI-5 and having a supervisor [χ^2 (1, N = 137) = 18.79, p < .001, Nagelkerke R^2 = 18.2%]

Model 1. Supervisor (WBI-5 'risk' group)

	B	SE	Wald	df	p	Exp(B)	95% CI for Exp(B)	
							Lower	Upper
Do you have a person, who supports you with regular advice connecting to your ministry? (Reference: have a supervisor)	-1.7	0.41	16.82	1	.000	0.18	0.08	0.41
Constant	-0.07	0.25	0.06	1	.800	0.94		

Model 2 – WBI-5 and having a spiritual director [χ^2 (1, N = 137) = 7.77, p = .005, Nagelkerke R^2 = 7.7%]

Model 2. Spiritual director (WBI-5 'risk' group)

	B	SE	Wald	df	p	Exp(B)	95% CI for Exp(B)	
							Lower	Upper
Do you have a spiritual director who meets you regularly, and support you in your personal relationship to God? (Reference: have a spiritual director)	-1.21	0.46	6.752	1	.009	0.30	0.12	0.74
Constant	1.08	0.41	7.01	1	.031	2.94		

Model 3 – WBI-5 and having a peer support group [χ^2 (1, N = 140) = 10.96, p < .001, Nagelkerke R^2 = 10.6%]

Model 3. Peer support group (WBI-5 'risk' group)

	B	SE	Wald	df	p	Exp(B)	95% CI for Exp(B)	
							Lower	Upper
Are you part of a group of pastors, wich meets regularly for supporting the members? (Reference: take part in a peer support group)	-1.24	0.38	10.43	1	.001	0.29	0.14	0.61
Constant	-0.19	0.26	0.58	1	.447	0.82		

Combined model – BDI-H and professional supports [χ^2 (3, N = 132) = 15.33, p = .002, Nagelkerke R^2 = 15.1%]

Combined model (BDI-H – non-normal level of depression)

	B	SE	Wald	df	p	Exp(B)	95% CI for Exp(B)	
							Lower	Upper
Are you part of a group of pastors, wich meets regularly for supporting the members? (Reference: take part in a peer support group)	-0.65	0.39	2.81	1	.094	0.52	0.24	1.12
Do you have a spiritual director who meets you regularly, and support you in your personal relationship to God? (Reference: have a spiritual director)	-0.93	0.47	3.95	1	.047	0.39	0.16	0.99
Do you have a person, who supports you with regular advice connecting to your ministry? (Reference: have a suprvisor)	-0.82	0.40	4.35	1	.037	0.44	0.20	0.95
Constant	0.43	0.34	1.57	1	.210	1.54		

Model 1 - BDI-H and having a supervisor [χ^2 (1, N = 138) = 7.86, p = .006, Nagelkerke R^2 = 7.6%]

Model 1. Supervisor (BDI-H – non-normal level of depression)

	B	SE	Wald	df	p	Exp(B)	95% CI for Exp(B)	
							Lower	Upper
Do you have a person, who supports you with regular advice connecting to your ministry? (Reference: have a suprvisor)	-1.02	0.37	7.64	1	.006	0.36	0.18	0.74
Constant	-0.10	0.26	0.15	1	.701	0.91		

Model 2 - BDI-H and having a spiritual director [χ^2 (1, N = 138) = 9.80, p = .002, Nagelkerke R^2 = 9.4%]

Model 2. Spiritual director (BDI-H – non-normal level of depression)

	B	SE	Wald	df	p	Exp(B)	95% CI for Exp(B)	
							Lower	Upper
Do you have a spiritual director who meets you regularly, and support you in your personal relationship to God? (Reference: have a spiritual director)	-1.29	0.44	8.56	1	.003	0.27	0.12	0.65
Constant	-0.24	0.21	1.29	1	.255	0.79		

Model 3 - BDI-H and having a peer support group [χ^2 (1, N = 141) = 3.06, p = .090, Nagelkerke R^2 = 2.9%]

Model 3. Peer support group (BDI-H – non-normal level of depression)

	B	SE	Wald	df	p	Exp(B)	95% CI for Exp(B)	
							Lower	Upper
Are you part of a group of pastors, wich meets regularly for supporting the members? (Reference: take part in a peer support group)	-0.62	0.36	3.03	1	.082	0.54	0.27	1.08
Constant	-0.28	0.25	1.24	1	.266	0.76		