

February 2016

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## Recommended Citation

Callaghan, Donna M. (2016) "Implementing Faith Community Nursing Interventions to Promote Healthy Behaviors in Adults," *International Journal of Faith Community Nursing*: Vol. 2: Iss. 1, Article 2.  
Available at: <http://digitalcommons.wku.edu/ijfcn/vol2/iss1/2>

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# Implementing Faith Community Nursing Interventions to Promote Healthy Behaviors in Adults

## **Cover Page Footnote**

Sources of Support: Widener University Provost Grant; Sigma Theta Tau International Eta Beta Chapter Grant; Clinton Global Initiative Grant (student) Acknowledgements: Alexis Caccavale, RN, BSN, Elizabeth Atchison, RN, BSN, Kaitlynn Rigley, RN, BSN (Widener University School of Nursing Pre-licensure Students)

Nurses have increasingly become important members of faith communities over the past couple of decades. One of the roles that a faith community nurse assumes is that of a health educator, who facilitates programs that promote the health and wellness of their faith communities. Bopp and Fallon (2013) reported a national study that assessed the rates, characteristics, and factors influencing faith-based health and wellness activities and suggested that a more in-depth assessment of the effectiveness of these activities on health behaviors and outcomes is needed. One study by Whisenant, Cortes and Hill (2014) did report the effectiveness of two faith-based health promotion programs where participants experienced weight loss and positive health changes as a result of the activities. The authors further stated that “faith community nurses are in an excellent position to address health issues and provide church members with tools they can use to become healthier” (p. 193). This literature supports faith-based health and wellness programming led by faith community nurses that can promote the practice of healthy lifestyles within their faith communities.

One major issue that faith community nurses encounter when providing health promotion programs for their faith communities is the recruitment of interested participants. Lefler (2009) offered “ten commandments of faith-based recruitment” that could help increase levels of participation in health promotion activities. A few of these recommendations included the use of culturally appropriate and age-sensitive recruitment and study materials, the use of incentives, and customizing spirituality (p. 243). Keeping these recommendations in mind when developing and implementing a program could help with recruiting and then maintaining interest of the participants. But sometimes even using these strategies do not lead to faith community interest so it may be necessary to take one’s faith community nursing practice outside of the walls of the church, leading to the promotion of health within the broader community. Balint and George (2015) reported how the faith community nursing scope of practice supports faith community nurses in extending access to healthcare to the broader community while providing wholistic care that is focused on the intentional care of the spirit. Therefore, the practice of a faith community nurse can be confined to the walls of the church or expanded into the broader community which can include other religious, health, social, and educational settings. This literature supports the role of the faith community nurse in developing health promotion interventions where the information, activities, and spiritual content are tailored for the specific participants, as well as implementing the program for the faith and broader communities.

## **Purpose**

The purpose of this manuscript is to report the implementation of faith community nursing interventions to promote healthy behaviors in adults. Callaghan (2015) suggested that more effective faith community nursing-led health promotion programs can be developed using theoretical frameworks that direct the content and teaching strategies used in the implementation of the programs. Therefore, the health promotion programs implemented in these reported studies were based on the integration of concepts/theories that have been tested in previous research. The programs were also customized for each of the populations/settings in relation to the healthy behaviors content, self-efficacy enhancing activities, and spirituality and/or religious preferences. These programs were taken to where the participants worked, studied, and socialized, which was an attempt at increasing the participation rates that could lead to more powerful studies as well as potentially providing evidence that faith community nursing interventions can be effective outside of the walls of faith communities. Finally, the outcomes of these programs were measured in order to document the effectiveness of the faith community nursing interventions.

## **Intervention Development and Implementation**

A health promotion program was developed based on the research findings of Callaghan (2003, 2005b, 2006c) who reported significant relationships among self-care agency, self-care self-efficacy, and health-promoting self-care behaviors in older adult, adult, and adolescent populations. Results from these studies also indicated that one's spiritual growth was significantly related to one's initiative and responsibility for self-care in all three populations. Other studies by Callaghan (2005a, 2006a, 2006b) reported that there was a significant relationship between the routine practice of religion and the performance of healthy behaviors. These findings as well as the concepts and theories used to guide these studies were used to develop a faith community nursing intervention that was implemented for three different populations within three different community settings which included families within a faith community, nursing students within a university, and older adults within a community setting. Orem's Self-Care Deficit Theory (Orem, 2001) was used to direct the supportive-educative nursing intervention. Pender's Health Promotion Model (Pender, Murdaugh & Parsons, 2010) and conceptualization of health-promoting self-care behaviors was used to develop the six topics included in the health promotion intervention. These topics included: spiritual growth, stress management, nutrition, physical activity, interpersonal relations, and health responsibility. Bandura's Self-Efficacy

Theory (Bandura, 1997) was used to develop the activities that increase self-efficacy levels of the health-promoting self-care behaviors (Callaghan, 2015).

The three intervention studies were pre-test post-test quasi-experimental designs with the hypothesis that the participants' practice of healthy behaviors would increase after participating in the health promotion program. The Health-Promoting Lifestyle Profile II instrument (HPLPII) (Walker & Hill-Polerecky, 1996; Walker, Sechrist, & Pender, 1987) was used to measure the pre-intervention and post-intervention levels of the participants' healthy behaviors since it has established reliability and validity in prior studies (Callaghan 2003, 2005b, 2006c). Paired t-Tests were the statistics used to test the hypotheses that participants' scores on the HPLPII would increase after attending the health promotion program. The studies were approved by the researcher's university IRB, letters of approval were obtained by each site where the program was offered, and participant consents were obtained prior to the start of each of the three programs to ensure the protection of human subjects. Also a power analysis was performed using an alpha level of .05, power of .80, and a medium effect size which indicated a sample size of 27 was needed for adequate power in each of the three studies. The methodologies used in each of the implementations of the interventions, including participant and protocol descriptions, are presented under separate headings.

### **Family Health Promotion Intervention**

The first intervention program was developed for this researcher's faith community and included information for families consisting of adolescents, adults, and older adults. The faith community was chosen as the setting for this program since faith community nurses can be important players in supporting older adults as they "age in place" (Rydholm, Moone, Thornquist, Alexander, Gustafson, & Speece, 2008). An intervention focused on the family was developed since nurse-facilitated family interventions could lead to adolescents practicing healthier lifestyles (Rew, Arheart, Thompson & Johnson, 2013). Adults were also included in this health promotion intervention since they are usually the support for the older adults and adolescents in their families. In order for these adults to be supports for their families they need to make self-care a priority.

Two Adult Clinical Nurse Specialist Students at this researcher's university assisted with the development of this faith community nurse-led health promotion across the life span program. Extensive literature reviews were performed resulting in the program consisting of six two-hour sessions on the topics of spiritual growth (foundation of health), stress management, nutrition,

physical activity, interpersonal relations, and health responsibility. One hour of each session was spent reviewing information on the specific topic presented via PowerPoint slides and discussing how the information relates to adolescents, adults, and older adults. The other hour was spent engaging in selected activities that focused on strategies which increase self-efficacy of that specific healthy behavior (Callaghan, 2015).

The health promotion program was presented by this researcher, who is the faith community nurse for this parish, for two hours per week for six consecutive weeks. The spiritual growth session included the definitions of spirituality and religiosity, the developmental aspects of and research related to spirituality, and ways one can increase spiritual growth across the life span. A family spiritual assessment tool and a guided meditation were used as the self-efficacy promoting activities for this session. The stress management session included the definition and signs and symptoms of stress in adolescents, adults, and older adults, and a presentation of a variety of stress management strategies. A stress assessment and a progressive muscle relaxation exercise were used as the activities for this session. The nutrition session included dietary recommendations for adolescents, adults, and older adults as well as family strategies that could promote healthy eating behaviors. The activity for this session included a three day diet recall/analysis and a discussion of ways to make healthier food choices. The physical activity session included research findings related to physical activity and health, daily recommendations for adolescents, adults, and older adults, and ways to increase daily physical activity. The self-efficacy enhancing activities for this session included a three day activity recall/assessment and a discussion of ways to increase daily physical activity. The interpersonal relations session included the developmental aspects of and research related to interpersonal relations, the role of the family in supporting members, and strategies that can influence the family's healthy behaviors. The activity for this session included a social support assessment as well as gratitude exercises. The health responsibility session included information regarding health promotion and disease prevention across the life span. Primary and secondary prevention strategies for the common health problems seen in adolescents, adults, and older adults were presented. The activity for this session included a family medical history that resulted in the development of a family genogram.

In order to be eligible to participate in the family health promotion program, the participant needed to be able to speak and read English, able to care for self, aged 14 and older, a member of the researcher's faith community, and able to attend with at least one other family member. Participants were recruited through a flyer describing the program that was placed in the church bulletin.

Incentives for attending this program included providing healthy snacks and refreshments during each of the six sessions. Eleven participants started the program which included three older adult couples, an older mother/daughter dyad, one mother/adolescent son dyad, and a middle-aged male. Four participants (two older adult couples) completed all six sessions of the program. These participants were married with a mean age of 65.25 and were high school educated.

The outcome measure for this intervention was the change in total scores of the HPLPII instrument. The mean of the pre-intervention scores was 140.5 and the mean of the post-intervention scores was 10 point higher at 150.25. However the paired t-Test scores were not significantly different ( $t = -1.92$ ,  $p = .075$ ) most likely due to the small sample size. Therefore, the intervention did increase the frequency of the participant's performance of healthy behaviors but the change was not significant.

### **Nursing Student Health Promotion Intervention**

The second intervention program was developed for nursing students within a university setting and included information for young adults as well as the resources available at the university that could assist them with their adoption of healthy behaviors. This setting was selected for the intervention because of an interest of two pre-licensure nursing students in the honors program from this researcher's university to assist this researcher in promoting the spirituality and health of their fellow nursing students. Bryer, Cherkis and Raman, (2013) recommended that since health-promoting behaviors of nursing students may be a predictor of academic success, health-promotion programs for this population may be beneficial. Also nurturing nursing students' spiritual growth may help the student develop the inner resources needed to deal with stress (Hensel & Laux, 2014). The two nursing students assisted with the revision of the original family health promotion program as well as the implementation of the program as part of their course work for the honors course. Since feedback from the participants who withdrew from the twelve hour family program stated the reason for withdrawing was that the program was too long, the program was revised to include six one-hour sessions on the topics of spiritual growth (foundation of health), stress management, nutrition, physical activity, interpersonal relations, and health responsibility. Thirty minutes of each session were spent reviewing information on the specific topic presented via PowerPoint slides and discussing how the information related to young adults and nursing students. The other thirty minutes were spent engaging in selected activities that focus on strategies that increase self-efficacy of that specific healthy behavior. The changes made to this study protocol were approved by this researcher's university IRB.

The health promotion program was presented by this researcher, who is a faith community nurse, as well as the two nursing students during three two hour sessions that covered two topics per session in order to fit with the students' academic schedules. Since this program was not being offered to families within a faith community but to nursing students within a university setting, the topics were tailored to the needs of the population. Specific information on the services that were available for students at the university which related to the topics covered was reviewed. For example the university had an "Interfaith Center" with a sacred space for individual or group worship as well as other organized student-led faith groups. Also since the university is not faith-based the focus of the program was on the importance of spirituality's influence on health and not specific religious beliefs so as to be inclusive of all faith beliefs.

In order to be eligible to participate in this health promotion program, the participant needed to be able to speak and read English, able to care for self, aged 18 and older, and a nursing student at the university. Students were recruited through an email with the flyer describing the program attached. Incentives provided for the students who attended the program included pizza, drinks, and snacks during each of the program sessions as well as credit for the activity by the school's Student Nurses Association. Thirty-six participants started the program with 23 participants completing all six sessions. The demographics of the participants included: mean age of 21; one male and 22 females; 18 white, one black, one Hispanic, and 3 mixed race; 87% were never married; 48% were sophomore students; and 74% lived in the university dormitories.

The outcome measure for this intervention was the same as the family intervention; there was a change in total scores of the HPLPII instrument. The mean of the pre-intervention scores was 146.2 and the mean of the post-intervention scores was 18 point higher at 164.4. The paired t-Test scores were significantly different ( $t = -5.2, p < .001$ ). Therefore, the intervention did increase the frequency of the participant's performance of healthy behaviors and there were significant increases in all six subscale scores (spiritual growth, stress management, nutrition, physical activity, interpersonal relations, and health responsibility).

### **Older Adult Health Promotion Intervention**

The third intervention was developed for older adults within an urban community senior center and included information focused on older adults living in a crime and poverty-stricken city. Resources available within the senior center and within the inter-city community that could assist the older adults with their adoption of



healthy behaviors were also included in the presentations. Because of the success of the student intervention and the university's commitment to civic engagement, another pre-licensure nursing student in the honors program from this researcher's university was interested in assisting this researcher in offering this program to older adults within the university's greater urban community. Research studies do indicate that African-Americans' spiritual and religious beliefs have a relationship with their healthy behaviors and self-care activities (Underwood & Powell, 2006; Watkins, Quinn, Ruggiero, Quinn, & Choi, 2013). This literature supported the emphasis of this intervention on spirituality and religiosity as the foundation of health and wellness in this specific population. The nursing student assisted with the revision of the original family health promotion program which involved customizing it for the participants and also assisted in the implementation of the program as part of the course work for the honors program.

The health promotion program was presented by this researcher, who is a faith community nurse, and the nursing student for one hour per week for six consecutive weeks. The program consisted of six one-hour sessions on the topics of spiritual growth (foundation of health), stress management, nutrition, physical activity, interpersonal relations, and health responsibility. Prayer was included in each of the six sessions after obtaining the support of the director as well as the senior attendees participating in this program. Thirty minutes of each session were spent reviewing information on the specific topic presented via PowerPoint slides and discussing how the information relates to community-dwelling older adults within the intercity setting. The other thirty minutes were spent engaging in selected activities that focus on strategies that increase self-efficacy of that specific healthy behavior.

In order to be eligible to participate in this health promotion program, the participants needed to be able to speak and read English, able to care for self, aged 50 and over, and a member of the senior center. The participants were recruited through a flyer describing the program that was posted around the senior center. Incentives to attend the program included healthy snacks during the sessions as well as a \$20 gift card for those participants who attended all six sessions. Twelve participants started the program with two completing all six sessions, one completing five sessions, and one completing four sessions. The demographics of the participants included: mean age of 73.7; one male and 3 females who were all Black/African-American; 3 were married and one was widowed; three completed high school and one completed grade school.

The outcome measure for this intervention was the same as the family and student interventions; there was a change in total scores of the HPLPII instrument. The mean of the pre-intervention scores was 132.75 and the mean of the post-intervention scores was 16 points higher at 139. The paired t-Test scores were significantly different ( $t = -3.1, p < .03$ ). Therefore, the intervention did increase the frequency of the participant's performance of healthy behaviors. However, there was only a significant increase in the total score and not the subscale scores as was seen with the student program. This result is most likely due to the small sample size and the fact that only two of the four participants completed all six sessions.

### **Implications**

The major finding of implementing these health promotion programs as part of a research study that measures outcomes in order to test a hypothesis is that health promotion interventions that focus on spirituality as the foundation of health and are led by faith community nurses can be effective in increasing the practice of healthy behaviors in adults. Also older adults and older adult couples were more interested in participating in health promotion activities than adolescents or adults most likely due to having the time to commit to these activities. Another implication of this study was that nursing students and community dwelling older adults were introduced to faith community nursing as well as the importance of spirituality and the effect it has on one's health. The nursing students also were introduced to self-care practices, including practices that can facilitate spiritual growth, who in turn can model and teach these healthy behaviors to others in their professional practices.

### **Limitations**

One of the main limitations of the studies was that the programs were offered to a convenience sample which resulted in small sample sizes, regardless of the fact that incentives were provided to increase participation. Refreshments were provided for the family intervention. Pizza and drinks were provided for the student intervention. The students who completed the program also received "points" toward their student nurse association service commitment. Snacks were provided for the older adult intervention as well as a \$20 gift card for completion of the program. The demographics of the samples were also quite homogeneous. The families that participated in the program consisted of older adult white couples. The student sample was mostly comprised of white females. The older adult participants were all Black/African American. These sample compositions

limit the generalizability of the results. Another limitation was the timing of the pre and post-assessments of healthy behaviors. In each program the pre-test was given within one week of the implementation of the intervention and the post-test was given within one week after the intervention was completed. This research design can only measure short term and not long-term healthy behavior changes. Also since the interventions for the three groups were similar but not exactly the same relative to content and length, the results of the three studies were interpreted individually. It was not this researcher's intent to compare the settings for score improvement especially since the sample sizes were small for two of the three studies.

### **Challenges**

The initial family health promotion program was offered to this researcher's parishioners in the summer of 2010 with four participants completing the program. In order to obtain more participants for the program and study it was offered to parishioners from all churches within the diocese in the summer 2011 with no interested participants. In the summer 2012 the program was offered to parish nurses as a train-the-trainer initiative so that each nurse could then offer the program to their parishioners with no interested nurses responding. The program was then offered to the congregations from all churches within this researcher's township in the summer of 2013 with no interested participants. This lack of success in implementing a faith community nursing intervention to increase healthy behaviors across the life span was the initiative to expand the walls of the faith community to include work, school, and/or social environments to see if a change in venue would increase participation rates. During the academic year of 2013 – 2014 the student program was implemented and in the academic year of 2014 – 2015 the older adult program was implemented with the assistance of three pre-licensure nursing students which led to more successful recruitment of participants.

### **Recommendations**

Considering the challenges previously identified, there is a need for strategies to increase the participation rates since the sample sizes for these studies were small for two of the three interventions. One strategy may include initiating partnerships with other local, regional, and national faith community nurses who could offer these programs to their faith communities and then merge the outcome data in order to increase the sample sizes and power of the study. Incentives to participate in the programs could also increase the sample sizes. However an assessment of

the potential participants to determine what incentives would result in their participation and commitment is essential. Once a health promotion program is initiated and the participants are committed to the program, data collected at other intervals post-intervention is needed to determine if the program results in long-term behavior change. Also when implementing a repeated measures study it may be necessary to establish healthy behavior support groups to encourage the long-term commitment to the practice of healthy behaviors.

### **A Health-Promoting Opportunity for Faith Community Nurses**

It is the opportune time for faith community nurses to play an integral role in the promotion of the health and wellness of persons within and outside of the walls of their churches. By promoting health of faith community members where they work, go to school, and socialize may increase the likelihood of participation in these health promotion activities. This outreach can also highlight the influence of spirituality on health and the role the faith community nurse plays in accomplishing the intentional care of the spirit, especially for those not belonging to a specific faith community. These reported studies are evidence that health and wellness activities can lead to an increase in healthy behaviors of those who attend these programs. It also is important to develop health promotion programs using theoretical frameworks that guide the teaching strategies used such as Orem's Self-Care Deficit Theory (2001), Bandura's Theory of Self-Efficacy (1997), and Pender's Health Promotion Model (2010) as were used to develop this health promotion intervention. An assessment of the program's potential participants is also important in order to tailor the intervention in terms of content, activities, time commitment, and incentives appropriate to increase participation. Finally forming health promotion partnerships with other faith communities locally, regionally, and nationally where outcome data can be combined through the use of common documentation methods can lead to more powerful interventions that promote the outcome of health as well as establish evidence of the effectiveness of faith community nursing interventions both within and outside of the walls of the church.

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