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Exploring the barriers and supports of faith community nurses serving in Alaska: A qualitative study

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Cover Page Footnote

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Introduction

Over 12,000 registered nurses have received additional education to serve as public health leaders and health educators in communities of faith (i.e., faith community nurses [FCNs] (King & Pappas-Rogich, 2011; Kruse-Diehr et al., 2021). FCNs, as described by the conceptual model of faith community nursing, deliver wholistic care (e.g., physical, mental, spiritual, emotional) and services (e.g., education, assessments, counseling) in various settings: home, congregations and faith communities, hospitals, clinics, and community agencies (American Nurses Association [ANA] & Health Ministries Association [HMA], 2017; McGinnis & Zoske, 2008; Zahnd et al., 2018; Ziebarth, 2014; Ziebarth, 2016). As a result, these nurses are uniquely positioned to design, implement, and enhance health education programs to address chronic disease prevention and health inequities and connect congregants to available community resources (ANA & HMA, 2017; Cooper & Zimmerman, 2017; Dandridge, 2014; Kruse-Diehr et al., 2021; McGinnis & Zoske, 2008).

While FCN research has gained prominence in the last few years, few studies have explored the lived experience of FCNs (e.g., support systems, barriers) (Bagley, 2011; Devido et al., 2017; Devido et al., 2019; Ziebarth & Miller, 2010). FCNs, many who are non-paid professionals, have reported unique challenges in their care delivery to faith communities, primarily related to training, funding, and finding available resources (Devido et al., 2017; Devido et al., 2019; Ziebarth & Miller, 2010). The broad roles and care FCNs deliver require adequate support to serve their faith communities effectively. Discovering these support needs requires understanding their lived experiences. Therefore, informed by the conceptual model of faith community nursing (Ziebarth, 2014; Ziebarth, 2016), this study aimed to explore the unique experiences of FCNs and document the barriers and facilitators when delivering care and services to faith communities in Alaska. Study findings will be used to inform future public health efforts among FCNs and enhance programmatic efforts of a statewide faith community resource center.

Methods

Participants

Data were collected from eight FCNs using in-depth, semi-structured interviews from January 2023 to June 2023. Eligible participants were 18 or older, trained as an FCN, and serving faith communities in Alaska. Participants were recruited through email, telephone, routine newsletters from a statewide faith community nurse resource center, and by snowball sampling (Patton, 2002). All participants received a $15 Amazon gift card as a thank-you for their time.

Protocol

After providing informed consent, participants were emailed a link to a brief demographic survey (e.g., age, gender, race/ethnicity) and asked to specify a day and time for a scheduled

interview. The principal investigator (PI), an expert in qualitative methods, conducted and recorded all semi-structured interviews via Zoom (~40-60 minutes in length). Once the transcripts were generated through Zoom, the PI read through each transcript while listening to the recording to correct any discrepancies. The topic guide used in each interview was developed and tested through qualitative research and content experts (DK, NTW, BB). Sample questions from the topic guide included: "How long have you served as a faith community nurse?", "How many congregations or faith communities do you currently serve?", and "What supports your ability to effectively perform your role as a faith community nurse?".

Statistical Analysis

Descriptive statistics were calculated for all demographic variables including age, gender, race/ethnicity, education level, years serving as FCN, years serving at church, church size, and church location (urban, rural). All quantitative data were analyzed using SPSS v.26. Qualitative data were coded using an inductive thematic analysis, which included six steps: 1) becoming familiar with the data, 2) creating initial codes, 3) identifying themes, 4) assessing generated themes, 5) defining themes, and 6) writing the report (Braun & Clarke, 2006). All transcribed interviews were analyzed using NVivo v.12.

Trustworthiness was maintained by ensuring credibility, confirmability, dependability, and transferability of qualitative data collection and analysis (Lincoln & Guba, 1985). An interdisciplinary triangulation of perspectives on the research team (e.g., Public Health, Psychology, Nursing) enhanced the alignment of participant responses with the interpretation of findings (Lincoln & Guba, 1985). Confirmability of the interpretation of findings was attained by developing a codebook to document participant perspectives. Additionally, regular research team meetings were scheduled to discuss the accuracy of data interpretation (Lincoln & Guba, 1985). An audit trail of study documentation (e.g., data collection and analysis, reports) was maintained to achieve dependability (Lincoln & Guba, 1985). Demographic data (e.g., age, gender, race/ethnicity) were collected to aid the transferability of findings to other FCNs serving in the state (Lincoln & Guba, 1985). The research team also engaged in memo writing (i.e., documenting thoughts and ideas) and reflexivity (i.e., self-reflection) to enhance the accuracy of findings and minimize investigator bias (Hennink et al., 2020; Strauss & Corbin, 1990).

Results

Eight FCNs completed the demographic survey and an in-depth interview. On average, FCNs were 73.3 (*SD* = 6.14) years old, had served as an FCN for 11.6 (*SD* = 6.78) years, and their current church for approximately 9.29 (*SD* = 7.89) years. All participants were non-paid professionals and served at churches in urban settings with an average of 146 members. Participants were mostly white (88%), female (100%), and had a 4-year degree or higher (4-year degree [50%], Professional degree [38%], Doctorate [13%]).

Qualitative Themes

Among questions exploring the lived experience of FCNs, the three major themes identified were: FCN roles, descriptions, and characteristics; barriers and challenges FCNs

experience while serving their faith communities; and existing support systems as well as the additional resources needed to enhance the ability of FCNs to serve their communities.

FCN roles, descriptions, and characteristics. An overview of participants' nursing background, reasons for serving as an FCN, and roles performed in faith communities are provided by this theme. Most participants (n = 5) spoke of their years of experiences as a registered nurse and unique expertise in pediatric care, infection control, catastrophic and polytrauma care as well as flight, school, and geriatric nursing. All participants (n = 8) also provided many reasons for serving in their faith community as an FCN including: an interest in helping and loving others in need (n = 3), receiving continuing education credits (n = 2), working closely with friends (n = 2), wanting to remain active or connected in the church (n = 2), being "pushed" into it (n = 1), maintaining volunteer hours to keep nursing license (n = 3), loving God and fulfilling God's plan (n = 2).

In addition, participants described their roles within the communities they served. For example, many participants noted they provided health education and information (e.g., infectious disease prevention, vaccines, blood pressure, and foot clinics). Many participants discussed how their role as an FCN consisted of "active listening" (n = 5), which a participant defined as "…when you come to the conversation with no preconceived agenda…" Participants also noted one of their main roles is to bridge or connect members to health services and resources (n = 5). Some participants described how they served their community as the COVID-19 response person (n = 4) during the pandemic (e.g., drafted mitigation protocols).

A few participants (n = 3) highlighted the importance of building trust with community members and how they had obtained trust within their communities. For example, one participant spoke of building trust by keeping information confidential and "doing what you said you were going to do" and another participant noted trust was achieved due to the "longevity of being here" and by being a "known entity" in their church family. In addition, one participant attributed established trust with community members because their church "holds faith community nurses in high esteem."

Barriers and challenges FCNs experience. When asked if COVID-19 influenced their ministry, most participants (n = 8) spoke about how the COVID-19 pandemic negatively impacted "the ability to provide parish nursing as it had been pre-COVID." For instance, participants described the increase in isolation of congregation members (n = 3), fewer continuing education classes being held through the faith community nurse resource center (n = 1), the inability to provide blood pressure screenings (n = 1), a lack of support from younger congregants on COVID-19 policies (n = 1), and the inability to use all senses (e.g., hug, handshake) due to an increase in "telephonic versus in-person care" (n = 1). One participant noted FCNs at their church moved out of state or became inactive during the pandemic and suggested "COVID had a real deleterious effect on the [FCN] program." In contrast, one participant noted, "COVID really pulled me in and gave me a concrete role as I was attempting to start our ministry." Some participants (n = 4) also connected the COVID-19 pandemic with their shrinking congregation (e.g., death, safety concerns, congregants moving away).

When asked about existing barriers within their ministry, a few participants discussed challenges connecting elderly congregants to care due to the healthcare system (*n* = 2). One participant stressed the importance of active listening and providing their clients with options for finding doctors who are a "good fit" for specific needs. This participant noted further due to insurance issues and healthcare facility closures, the options for congregants are becoming "much sparser." Similarly, another participant explained elderly congregants are experiencing long wait times for appointments with new providers because of the limited options for senior care.

Participants also discussed how role expectations and distinctions impact their ability to serve as an FCN. For example, due to the autonomous nature of the role, participants lack formal support structures as described by a participant's statement, "You have no power base," further increasing the time to "build trust" with congregants. In connection, one participant discussed keeping monthly timesheets of their hours served as an FCN, while other participants noted the difficulty of tracking hours because the FCN role is "ongoing all the time…" or "it's just part of what I do." Another participant described how the FCN role they serve at their specific church is "very unstructured," making it "hard to know when you're in the role or when you are not."

Existing support systems and needed resources. This theme provides insight into FCNs' perceptions of factors promoting or impeding the delivery of services. Participants discussed the importance of receiving support from church leadership (*n* = 5), staff (*n* = 2), and the congregation (*n* = 2). One participant perceived an overlap in the roles of a pastor and an FCN by stating a "very involved pastor does a lot of that [listening, praying, following-up, and other FCN-related care]. It becomes a facilitator and a barrier." Another participant highlighted how they no longer have the necessary support due to leadership changes (e.g., no full-time pastor). Most participants (*n* = 6) also described the statewide faith community resource support center as a major support for their ministry. For example, participants spoke about the various services the resource center provides including ongoing training and coursework, regular meetings, informational newsletters, and support groups.

A few participants discussed personal factors that help their ministry. Three participants described their faith and relationship with God as one of the main supports for serving as an FCN. Some participants (*n* = 2) described utilizing the Internet to find resources and information. Participants also credited their children (*n* = 1) and spouse (*n* = 1) as supporters and advocates for them and their FCN ministry.

When discussing their role in addressing mental health needs, FCNs mostly provided unique perspectives across interviews. To address mental health needs directly, some participants noted they felt "unqualified" (*n* = 1) or "…I don't see the parish nurses, at least myself having a skill set that's going to deal with the mental health issue…" (*n* = 1). One participant provided an important distinction for the role of an FCN when attempting to address differing mental health needs (e.g., emotional well-being and psychiatric diagnosis). Specifically, this participant stated when working with a client having a true psychiatric illness, "As a faith community nurse, you're just gonna do a lot of loving and listening, because that's not our role at all, that person needs true psychiatric guidance." Two participants noted their role would be to direct or refer individuals to other resources for help with mental health issues. Some participants (*n* = 2) alluded to the "complicated" nature of adults knowing mental health treatment will help but also having the

"right to stay miserable" or not being "in a place that they really want to take that on." One participant spoke of using their FCN network when addressing mental health needs by saying "…if somebody comes with a question and we don't know how to answer it or where to go, we'll just put it out there for all of us [FCNs] to answer and figure out…"

When asked about additional resources needed for established FCNs, participants (n = 4) highlighted a few items including more education on vulnerable communities (e.g., autism spectrum disorder, LGBTQIA+ populations, and people experiencing domestic violence), marketing for younger nurses, incorporating faith community nursing curriculum into academic nursing programs, having a core of nurses and mentor program, and access to health literature libraries (e.g., academic literature). Some participants (n = 4) also discussed helpful resources for new FCNs. For example, two participants suggested starting a mentoring or buddy program. One participant noted they would ask new FCNs their purpose for starting this role and if they were comfortable with being independent. Another participant said they would advise new nurses to "get to know the people" and "listen" to their congregation.

Discussion

The goal of this study was to provide in-depth insight into what FCNs experience while serving faith communities. Findings align with previous research showing FCNs provide multi-level, wholistic individual- (e.g., active listening, health care referral, prayer) and congregational-level care (e.g., health education, health screenings) to the communities they serve as non-paid professionals (Paterson et al., 2021; Ziebarth, 2016). With that said, the wholistic care and services delivered by FCNs may be influenced by various factors including the level of trust built with their faith communities (Chase-Ziolek & Iris, 2002; Tuck & Wallace, 2000), perceived expectations from community members (Ziebarth & Miller, 2010), and the environment (e.g., health care system, client health insurance, global pandemic) (Devido et al., 2019).

Our findings suggest COVID-19 pandemic guidelines limited the ability of FCNs to deliver care and provide care to reduce the risk of spreading COVID-19, which contrasts with previous findings that pandemic restrictions had little impact on FCNs' ministries (Long, 2021; Ziebarth et al., 2024). While not assessed in our study, previous research has shown FCNs in Appalachia experienced higher levels of stress and compassion fatigue providing care during the pandemic (Smothers et al., 2023). Future research should continue to examine how FCNs navigate the individual, social, and environmental factors influencing their ability to deliver wholistic care. Moreover, attention should be given to exploring the impact of stress, burnout, and compassion fatigue on FCN numbers and sustainability of FCN networks, while developing strategies to address FCN mental health and self-care needs. Further, to gain a better understanding of how COVID-19 impacted the FCN ministry, future researchers may consider qualitatively exploring perspectives from FCNs serving in ministries across the United States.

Further, while the pandemic hindered the type of care and services FCNs delivered, findings revealed some FCNs were tasked with drafting COVID-19 mitigation protocols for their congregations and other communities served. For decades, FCNs have been utilized as resources for implementing congregational-based health promotion programs. Now, the provision of evidence-based policy recommendations to enhance congregational health, safety, and emergency

preparedness is also included in their specialty (Hellman, 2022; Knighten et al., 2021; Shackelford et al., 2023). Thus, future research may warrant assessing the effectiveness of the policy-level changes designed and implemented by FCNs. In addition, future researchers should continue to evaluate the training FCNs receive on emergency preparedness and contagious disease mitigation.

Tasked with performing various roles as non-paid professionals, the sustainability of FCN programs may depend on the structural support received (e.g., funding, support, resources) (Devido et al., 2017; Devido et al., 2019). Our findings are consistent with the literature showing the importance of perceived and tangible support of faith leaders, particularly due to their influence on congregational buy-in for health promotion resources (Bagley, 2011; Young, 2016). Additionally, consistent documentation of hours served, and care provided is necessary to enhance further structural support (Hixson & Loeb, 2018; Parker, 2004; Paterson et al., 2021). FCNs, in the study, highlighted the difficulties of documenting their services due to various factors. These findings may necessitate future research to conduct work following a cohort of congregations across time to assess the impact of church leadership support or lack thereof on the sustainability of the FCN ministry. Moreover, there is a need for future research to develop and test the acceptability and feasibility of a comprehensive documentation system for FCNs.

Previous literature has shown, in some cases, FCNs may have limited access to educational and other resources for their ministry (Schweitzer et al., 2002). Of note, FCNs, in this study, were supported by a statewide FCN resource center, which provides training, resources, support, continuing education, and consulting services. Despite this, study findings highlighted FCNs may still need more support especially related to increased marketing to younger nurses and academic nursing programs to enhance the FCN ministry, and up-to-date educational resources for serving vulnerable communities. Thus, continued multidisciplinary collaborations (e.g., academic, medical, community) may be necessary to identify and address unmet educational and resource needs among FCNs.

Despite these findings, this study was not without limitations. Although in-depth insight was gleaned from each interview, our small sample size may have limited our ability to reach saturation across themes which may further reduce the transferability of findings. To include more FCNs, future qualitative research with FCNs should offer both virtual and in-person interviews. Our sample lacked diversity regarding race and ethnicity as well as faith tradition. To address this, future researchers should purposively sample FCNs to ensure diverse perspectives are represented in the lived experiences of FCNs.

Conclusions

FCNs, many of whom are non-paid professionals, have trusted voices and are considered public health leaders in many community settings. Despite this, it is apparent FCNs experience unique challenges, particularly due to environmental factors outside of their control, which impact their ability to provide care and sustain their ministry. Findings from this study suggest additional work is needed to continue equipping FCNs with the necessary tools and resources for effective service to their communities.

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