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THE ROLE OF FAITH LEADERS IN PARTNERSHIPS AMONG HEALTH
PROMOTION RESEARCHERS AND FAITH COMMUNITIES

A dissertation submitted in partial fulfillment of the requirements for the degree Doctor
of Philosophy at Virginia Commonwealth University.

by

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ABSTRACT

THE ROLE OF FAITH LEADERS IN PARTNERSHIPS AMONG HEALTH PROMOTION RESEARCHERS AND FAITH COMMUNITIES

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A dissertation submitted in partial fulfillment of the requirements for the degree Doctor of Philosophy at Virginia Commonwealth University.

Virginia Commonwealth University, 2011

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Faith communities are often used as sites for health promotion research and the leaders of those faith communities play an important role in successful campus/faith community partnerships. This study examined (a) faith leaders' definitions of health, (b) ways in which faith leaders envision campus/faith community partnerships to be structured, and (c) faith leaders' perceptions of the roles that faith leaders may assume in such partnerships. Grounded theory methodology was used. In depth interviews were conducted with ten clergy members.

The findings revealed that clergy embraced a holistic definition of health. They expressed a desire to participate in studies that resulted in improved health and contributed to improved relationships with the university. The clergy's perceived roles in research that emerged from this study were (a) provide approval, (b) recruit

participants, (c) identify volunteers, (d) lend influence, (e) keep information flowing, (f) serve as spiritual teacher/educator, and (g) provide input on the study design. A theory of the process of negotiating clergy roles emerged from the data. This theory suggests that the process of negotiating clergy roles is a fluid and iterative process that occurs at several phases of the research process from entertaining a proposal to participate in research through conducting the study.

Implications for researchers include (a) investing time to develop relationships with faith communities, (b) identifying the importance of a holistic definition of health, (c) maintaining flexibility regarding the roles clergy may assume, and (d) identifying links between study objectives and the mission of the congregation.

CHAPTER 1

Background for the Study

Community engaged scholarship is a growing movement on university campuses (Driscoll, 2008). Health promotion and medicine are among the disciplines that have embraced the call to community engagement. This project was designed to study potential methods of conducting community engaged scholarship. Health promotion researchers often work with and in communities. Although most health promotion research is conducted within the context of communities, the type of community and nature of involvement vary significantly among research studies. The setting for this study focuses on research conducted with or in one particular type of community—faith communities.

Faith communities are widely used as the site of health promotion and health education research. They are natural partners with health promotion researchers because of a common commitment to social justice and service to the community (Gee, Smucker, Chin, & Curlin, 2005). However, differing values, methods and processes of accomplishing work, and organizational structures can cause challenges that must be identified and addressed in order to create functional partnerships (Laken, Wilcox, & Swinton, 2007). For example, research suggests that faith communities value research projects that are congruent with their missions and are respectful of church priorities (Atkinson et al., 2009; Kaplan, Calman, Golub, Ruddock, & Billings, 2006).

Investigators may have to adjust their work schedules and methods to accommodate the schedules of the faith community. Typically, volunteers play a major role in the functioning of faith organizations, and researchers need to develop working relationships that accommodate the time constraints of a volunteer organization (Laken et al., 2007). This may involve holding meetings in the evenings or on weekends when congregation members are available rather than during standard working hours.

Within working relationships between health promotion researchers and faith communities, clergy have been identified as highly influential individuals within the partnerships (Markens, Fox, Taub, & Gilbert, 2002). Clergy are viewed as role models, teachers, motivators, decision makers, and hold a position of authority that can be used to champion health messages (Atkinson et al., 2009; Demark-Wahnefried et al., 2000; Laken et al., 2007). This study examines faith leaders' perceptions of one of the organizational components of university/faith community partnerships for research—their role in university/faith community partnerships for health research.

Statement of Problem

The extent of the involvement of the faith community in health promotion research projects varies widely. Community-engaged research (CEnR) covers a spectrum of partner involvement from community-placed to community-based participatory research (CBPR). Community-placed research is a common form of health promotion research in faith communities. In community-placed research, faith communities

function as recruiting venues and locations for delivering programs. Churches are viewed as locations where sufficient numbers of people within the target population gather regularly and are available to be research participants. Generally, in these studies, the faith community has no input into the design or conduct of the research (Duan, Fox, Deroose, & Carson, 2000). CBPR occupies the other end of the spectrum of community partner involvement.

CBPR is an approach to research that engages the community as partners in the research including participating in the design, shared funding, and joint ownership of data (Israel, Schulz, Parker, & Becker, 1998). In the context of faith communities, CBPR projects may be designed to be faith-based programs that incorporate faith constructs into the design and delivery of the program (Ammerman et al., 2003; Kaplan et al., 2006). For example, Bopp et al. (2007) explored the connection between spiritual beliefs and health beliefs. Holt et al. (2009) compared spiritually-based and non-spiritually-based educational interventions for prostate cancer screening decision-making for African American men. In a qualitative investigation of the community partner experience in breast cancer interventions in churches, pastors expressed the desire to develop and incorporate breast cancer information into sermon content (Markens et al., 2002).

The available literature points out that successful research partnerships engage the clergy in the partnerships in some capacity such as recommending individuals to be lay health advisors, incorporating health messages in sermons, being the champion for the intervention or serving as a role model of healthy lifestyle choices (Alder et al., 2007;

Ammerman et al., 2003; Baskin, Resnicow, & Campbell, 2001). Currently, the research on the roles clergy assume in partnerships is limited. The vast majority of the attempts to delineate clergy roles have been a by-product of intervention research studies focusing on such topics as cancer prevention, diabetes prevention and management, and increasing fruit and vegetable intake and that were not specifically designed to assess the role of clergy (Atkinson et al., 2009; Demark-Wahnefried et al., 2000; Markens et al., 2002). The literature suggests that clergy support and cooperation are key components to a successful studies (Bopp et al., 2007; D. M. Griffith, Pichon, Campbell, & Allen, 2010a; Matthews, Berrios, Darnell, & Calhoun, 2006). However, no attempts have been made to develop either a theoretical or a conceptual framework for the role of clergy that could be used in study design.

Rationale for Study of Problem

The purpose of this study was to develop a grounded theory of the role(s) clergy, as the leaders of faith organizations, may assume in health promotion research conducted in faith communities. Specifically, the study explores partnerships among university health promotion researchers and faith communities. The interview process explored their perceptions of the types of roles they could assume, ways in which they might potentially influence partnership construction and execution, and the expectations that they have for university/faith community partnerships for health research. Specifically, the project explores (a) clergy members' definitions of health, (b) their attitudes toward

methods of conducting research, (c) their role and outcome expectations, (d) decision-making processes, (e) trust, and (f) other issues that potential partners bring to health promotion research projects.

Research studies aimed at developing theoretical models of faith community-university partnerships are rare. Baskin and colleagues (2001) have begun to work on theory development of faith community-university partnerships. Their work is specifically related to the university partnerships with Black churches. They developed a theory of partnerships that involves two dimensions of cultural sensitivity. However, their theory does not incorporate organizational factors, factors related to specific religious or theological beliefs, or power dynamics in the partnerships. A model of faith and health initiatives from a Judeo-Christian perspective was developed that addressed aspects of effective faith community-public health partnerships (Ramsey, 2004). This model included leaders as a central element of the model of these partnerships. Both of these studies contribute to the development of a theory of faith community-university partnerships but both are limited. Baskin et al. (2001) is specific to African American Christian churches. It addresses only issues of cultural sensitivity that have not been tested in other settings. Ramsey's (2004) work was confined to religious organizations with a Judeo-Christian orientation and included both researchers and public health practitioners as potential partners. The review of the literature thus far has not revealed any research that has attempted to develop theory specifically related to the role of clergy in effective university/faith community partnerships.

Overview of the Literature Review

Frameworks for Community Engagement

This section of the literature review presents a general overview of CEnR as it has been utilized in community partnerships for health. CEnR is an approach to research that incorporates community engagement in the research process at varying levels (Ross et al., 2010). CBPR is one form of CEnR that is a commonly utilized approach to faith community partnerships. In their seminal work on CBPR, Israel and colleagues (1998) outlined the guiding principles of CBPR. These principles can be utilized to form working relationships in academic/faith community partnerships. Additionally, researchers have proposed practical guidelines for effective university/community partnerships (Ross et al., 2010). These principles and practical guidelines are presented as they relate to university/faith-community partnerships.

General Theories, Models and Characteristics of Health Promotion Research in Faith Communities

A scant body of research aimed at developing theories or models related to effective university/faith community partnerships exists. However, several articles outline characteristics of successful partnerships such as engendering support from congregational leadership, trust and respect, the implications of organizational structures, and the involvement and support of umbrella organizations. (Atkinson et al., 2009; Kaplan et al., 2006; Kaplan et al., 2009; Laken et al., 2007). Of those articles that present

models, each takes a unique approach to developing their models. Baskin and colleagues (2001) described a successful multidimensional model of partnerships between university researchers and African American churches that focuses on cultural sensitivity. Ramsey (2004) developed a 10-construct model of faith and health in Judeo-Christian communities in South Carolina. The 10 constructs—(a) theological assets, (b) faith leaders, (c) history, (d) congregational assets, (e) congregation's faith, (f) physical organizational assets, (g) community needs, (h) congregational needs, (i) partnership, and (j) public health community—inform the construction of university/faith community partnerships and the role of clergy as spiritual leaders in these partnerships. Moreover, they provide insight into the clergy's perceptions of health. Another model, the Healthwise Collaboration Model (HCM) delineates stages of interaction through which campus/church partnerships may progress (Carter-Edwards, Jallah, Goldmon, Roberson, & Hoyo, 2006). As partnerships evolve through the stages of the model, levels of trust and resource sharing increase.

Selected Literature—Health Promotion Initiatives in Faith Communities

Health promotion and disease prevention intervention research is often situated in faith communities, and, as often-used sites for interventions, the various constructions of these interventions require attention in this literature review (DeHaven, Hunter, Wilder, Walton, & Berry, 2004). The studies included in this review of the literature represent a wide range of community engagement levels from community-placed to fully functioning CBPR interventions. The topics of the interventions include a wide variety of

interventions such as increasing physical activity, increasing fruit and vegetable intake, cancer prevention behaviors, cardiovascular disease prevention, HIV/AIDS prevention, diabetes prevention and management, eliminating health disparities, weight loss, mental health education, and stroke risk education. Select, empirically-based studies, both quantitative and qualitative, representing the breadth of the types of interventions and the spectrum of community engagement are reviewed. Studies in which the role of clergy was discussed will be included in the following section.

Role of Clergy in University/Faith Community Partnerships

The final section of the review of the literature examines those studies that speak directly about the role of clergy in university/faith community partnerships for research. Examinations of the role of clergy in university/faith community partnerships have been primarily conducted as a secondary line of inquiry within larger studies of the effectiveness of health promotion interventions in faith communities (Atkinson et al., 2009; Baruth, Wilcox, Laken, Bopp, & Saunders, 2008; Kaplan et al., 2006; Kaplan et al., 2009). For example, REACH 2010 is a Centers for Disease Control and Prevention (CDC) funded program for cancer control interventions. It has been implemented in many cities throughout the United States. Some of those interventions have been conducted in faith communities and an assessment of the partnership has been one aspect of those interventions. Some researchers have gleaned insights into the role of the clergy through research into the elements of effective university/faith community partnerships (Laken et al., 2007; Markens et al., 2002; Rodriguez, Bowie, Frattaroli, & Gielen, 2009).

Ammerman and her colleagues (2008) specifically explored the research experiences of African American church leaders who participated in a CBPR study.

Research Questions

While there is an emerging body of literature that explores the nature of partnerships between health promotion researchers and faith communities, the specific role of the clergy has not been explored in depth. Specifically, explorations of the clergy perspective have been limited (Ammerman et al., 2003; Markens et al., 2002). This research examines questions related to university/faith community partnerships for health research and the potential role of clergy from the perspective of clergy through two primary lines of inquiry.

The “most powerful aspect of community participation in health intervention projects is that it forces the projects to address the health concerns of community members rather than the concerns of health professionals [or health promotion researcher]” (Arcury, Austin, Quandt, & Saavedra, 1999, p. 564). Definitions of health are socially constructed and vary from one social context to another (Boddington & Räisänen, 2009; Collins, Decker, & Esquibel, 2006; Damron-Rodriguez, Frank, Enriquez-Haass, & Reuben, 2005). Accordingly, the first area of inquiry examines the health issues salient to the faith leaders and the sources of these perceptions.

1. What are faith leaders’ perceptions of the most important health issues to be researched?

- a. What are the sources of these perceptions?

A second line of inquiry relates to the clergy's perceptions of the ways in which effective university/faith community partnerships might be structured and their own role in these partnerships.

2. How do faith leaders envision a partnership between faith communities and health promotion researchers to be structured to address the most pressing health concerns facing their congregations and communities?
3. What do faith leaders perceive as their role in health promotion research?
 - a. What are the benefits of assuming this role?
 - b. What are the barriers to assuming this role?
 - a. How could they more effectively perform this role?

Overview of the Methodology

This qualitative study utilizes an emergent design based on grounded theory methodology (Corbin & Strauss, 2008). Grounded theory was chosen as the methodology for this study because of the paucity of existing theory related to the role of clergy in university/faith community partnerships. According to Glaser and Strauss (1967) one of the functions of theory is to “guide and provide a style for research on particular areas of behavior” (p. 3). Charmaz (2009) speaks of theory as describing processes. This study developed theory related to behaviors of partners in

university/faith community partnerships for research and the processes involved in determining the roles that clergy may play in these partnerships.

Definition of Terms

The following terms are pertinent to an understanding of the study.

The Black (African American) Church

The Black Church in American, while not homogeneous, shares a common religious and cultural ethos. The Black Church “refers to those independent, historic, and totally African American controlled denominations that constitute the core religious experience of the majority of African American Christians (e.g., African Methodist Episcopal Church [AME]; National Baptist Convention, USA, Inc., [NBC]; Church of God in Christ [COGIC]) (Molock, Matlin, Barksdale, Puri, & Lyles, 2008, p. 324-325).

Community

Community as a unit of identity within CBPR “is characterized by a sense of identification and emotional connection to other members, common symbol systems, shared values and norms, mutual—although not necessarily equal—influence, common interests, and commitment to meet shared needs” (Israel et al., 1998, p. 178).

Community-placed Research

Community-placed research involves research projects that are conducted *in* a community. The community is viewed as a place or setting in which community

members are not actively involved with the research project (Israel et al., 1998). The research is designed and controlled by the investigator.

Community-based Research

Community-based research is an approach to research that occupies the middle of the spectrum of community involvement in research. In community-based research the investigator maintains control of the design of the research but draws upon community resources (often volunteers or communications systems in faith community research) to conduct the research (Yale CARE Ethical Principles of Engagement Committee, 2009).

Community-based Participatory Research (CBPR)

The working definition of CBPR that will be utilized in this study is based on the W. K. Kellogg Foundation Community Health Scholars Program definition of CBPR. For this project CBPR is “a collaborative approach to research that equitably involves all partners, both university researchers and community members, in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community and has the aim of combining knowledge with action to improve health outcomes for the [congregation and/or its surrounding] community” (Faridi, Grunbaum, Gray, Franks, & Simoes, 2007, p. 2) CBPR emphasizes conducting research *with* communities rather than *in* communities.

Community-engaged Research (CEnR)

CEnR for health involves working at “the intersection of the complementary efforts of the lay community, community non-profit organizations, health practitioners and medical and public health researchers to improve health” (Clinical and Translational Science Award [CTSA] Consortium’s Community Engagement Key Function Committee and the CTSA Community Engagement Workshop Planning Committee, 2009, p. 4).

CEnR is a term utilized primarily in health research.

Community Engaged Scholarship

The Carnegie Foundation for the Advancement of Teaching states that community engagement “describes the collaboration between institutions of higher education and their larger communities (local, regional/state, national, global) for the mutually beneficial exchange of knowledge and resources in a context of partnership and reciprocity” (The Carnegie Foundation for the Advancement of Teaching, 2010, n.p.). Specifically, this research focuses on the Outreach and Partnerships category of community engagement as defined by the Carnegie Foundation with special emphasis on the partnerships aspect of the category. “Outreach focuses on the application and provision of institutional resources for community use with benefits to both campus and community. The partnerships aspect focuses on collaborative interactions with community and related scholarship for the mutually beneficial exchange, exploration, and application of knowledge, information, and resources (research, capacity building, economic development, etc.)” (*Clinical and translational science awards: Strategic goals.*, n.p.). Community engaged scholarship encompasses the breadth of community

engaged scholarly activities while community-engaged research is a term normally used in the context of health research.

Grounded Theory

Grounded theory is one form of qualitative research in which theory is derived from “data, systematically gathered and analyzed through the research process” (Corbin & Strauss, 2008, p. 12). Grounded theory begins with an area of study. The theory emerges from the process of data collection and analysis rather than a predetermined hypothesis.

Health Ministries

Health ministries are ministries within a church that specialize in integrating faith and health for the church’s parishioners and its surrounding community (Carter-Edwards et al., 2006). Activities of health ministries may include conducting health screenings, providing health education, and caring for parishioners with specific health needs.

Health Promotion Researcher/Investigator

For purposes of this study, health promotion research or investigator refers to researchers who are affiliated with universities. Although health promotion research is conducted by other entities such as health departments or other governmental agencies, this project specifically examines researchers from universities in order to study community engaged scholarship (Driscoll, 2008).

Parish Nursing

Parish nursing is a specialty practice within nursing that integrates spiritual care for individuals with the nursing standards of care including assessment, nursing diagnosis, outcome identification, planning, implementation, coordination of care, health promotion, health counseling, and evaluation (Healthy 100 Church Ministry Parish Nurse Institute)().

Religion

Religion and spirituality are related, and sometimes overlapping, concepts. Religion is “an organized system of beliefs, practices, rituals, and symbols designed to facilitate a relationship to and understanding of a deity (or deities) as well as to promote understanding and harmony of a person’s relationship to oneself and others in living together in community” (Thoresen, 1998, p. 415).

Spirituality

Spirituality is a broader construct than religion. It involves a unique search for meaning or purpose in one’s life, but does not necessarily include religion. The defining characteristic of spirituality is a search for the sacred. Spirituality reflects “the quality of one’s transcendent relationship to some form of a higher power, spirit or force” (Thoresen, 1998, p. 415).

CHAPTER 2

Methodology of the Review of the Literature

The researcher searched the literature related to faith community-based health promotion interventions from 2000 to 2010. The decision to search from 2000 forward was based on a shift in research emphasis that began in 2000. The U.S. Department of Health and Human Services sets public health objectives for the nation every 10 years. Healthy People 2010 was implemented in 2000 and had two overarching goals. The first was to increase quality and years of healthy life. The second was to eliminate health disparities (U.S. Department of Health and Human Services, 2001). Significant disparities in health status exist along racial/ethnic lines for most health conditions including cancer, cardiovascular disease and obesity (Smedley, Stith, Nelson, & Institute of Medicine (U.S.). Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, 2003). Significant disparities exist between African Americans and their White counterparts. African Americans experience poorer health status than Whites in virtually every measure of health resulting in lower life expectancies for both males and females (Franks, Muennig, Lubetkin, & Jia, 2006). As researchers looked for ways address the situation, African American churches became a reasonable avenue for researchers to pursue. African American churches have long served as a significant institution in the life of the African American community as a center of social, political and spiritual life (Baskin et al., 2001). These characteristics of

African American churches are some of the factors that have influenced the increased emphasis on church-based health promotion interventions since 2000 in predominantly African American churches.

Searches of the peer-reviewed literature were conducted using the terms “health promotion”, “health education”, “clergy”, “pastor”, “faith community”, “church”, “religious leader”, “religion”, “religious leader” and “faith” in the combinations described in Table 1. The searches returned 378 results with 43 duplicates.

Table 1: Literature Search Criteria and Returns

Search terms	Data base	Number of returns
Health promotion and clergy	Pub Med	36
Health promotion and pastor	Pub Med	11
Health education and pastor	Pub Med	29
Health education and clergy	Pub Med	48
Health education and faith community	Pub Med	14
Health promotion and faith community	Pub Med	20
Health education and church	Pub Med	202
Health promotion and religious leader	Pub Med	1
Health promotion and clergy	Religion & Philosophy collection	1
Health promotion and religion	Academic Search Complete	12
Health promotion or health education and faith or clergy or church	EBSCO: CINAHL, PsychInfo	4
Total Articles Found		378
Duplicates Removed		43
Articles Vetted		335
Articles Included		90

Once the duplicates were removed, the articles were vetted according to the following criteria. The impact factors of the journals in which the articles appeared were one factor, particularly in vetting the health promotion intervention literature. Table 2 contains the impact factors of the journals and the number of articles used from each journal. All relevant articles from the *American Journal of Public Health* were included since that is the journal of the American Public Health Association, the primary professional association for public health professionals. The journals with impact factors between 1.0 and 3.0 are all national or international journals utilized by public health researchers and practitioners. The *Journal of Religion and Health* is the only journal specifically examining the intersection of the disciplines of religion and health. *Ethnicity & Disease* and the *Journal of Health Care for the Poor and Underserved* both publish work related to minority and underserved communities. Particularly for literature related to health promotion intervention studies, *Ethnicity & Disease* and the *Journal of Health Care for the Poor and Underserved* are the distribution venue for a large number of health promotion studies in African American churches. While these studies may not be as well-recognized in the academic community as those in more recognized public health journals, the way in which the studies were conducted may impact the perceptions of clergy and congregation members. Therefore, a selection of articles from these journals was included in the review of the literature.

Table 2: Journal Impact Factors as of August 2010

Journal	Impact Factor	Number of Articles Cited
<i>Annual Review of Public Health</i>	7.915	2
<i>American Journal of Public Health</i>	4.371	5
<i>American Journal of Preventive Medicine</i>	4.235	1
<i>Health Psychology</i>	3.462	1
<i>Social Science Medicine</i>	2.710	2
<i>Journal of Urban Health</i>	2.205	1
<i>Health Education & Behavior</i>	2.194	4
<i>Health Education Research</i>	2.146	2
<i>Journal of Public Health Management & Practice</i>	1.413	2
<i>Journal of Community Health</i>	1.392	3
<i>Public Health Nursing</i>	0.813	1
<i>Journal of Cancer Education</i>	0.52	1
<i>Journal of Religion and Health</i>	0.358	1
<i>AIDS Education and Prevention</i>	Unlisted	2
<i>Cancer Practice</i>	Unlisted	1
<i>Diabetes Educator</i>	Unlisted	1
<i>Ethnicity & Disease</i>	Unlisted	2
<i>Health Promotion Practice</i>	Unlisted	1
<i>Journal of Ambulatory Care Management</i>	Unlisted	1
<i>Journal of Health Care for the Poor and Underserved</i>	Unlisted	2
<i>Preventing Chronic Disease</i>	Unlisted	1

<i>Public Health Reports</i>	Unlisted	2
<i>Southern Medical Journal</i>	Unlisted	1
<i>Suicide & Life Threatening Behavior</i>	Unlisted	1
<i>Urologic Nursing</i>	Unlisted	1

Studies that utilized churches as one of several community-based organization sites were excluded. Parish nursing is a unique mode of addressing health in faith communities that combines the delivery of health services with health education. Studies analyzing the use of parish nurses in churches were eliminated because of the health provider role assumed by many parish nurses. Additionally, several studies utilized churches as one of several community venues for recruiting participants. These studies were discarded. Pilot studies were also eliminated.

The reference lists for the research included in the literature review provided another sources of literature. The reference lists were reviewed and pertinent literature (using the same criteria as listed above) was included in the literature review.

Community-engaged Research and Scholarship

Additional searches were conducted for relevant literature related to community-engaged research and community-engaged scholarship. A search for “community engaged research” in Pub Med yielded 12 articles. Of those 12 articles only two were related to general CEnR in health and were included in this review. A similar search using “community engaged scholarship” in Pub Med yielded four results from which one

article was germane to the research. A search of Academic Search Complete with the search terms “community engaged scholarship” produced 19 results. Four articles addressed health, three of which were included in the review. An additional hand search of the reference lists of the articles retrieved from the automated searches comprises the remaining articles used in this literature review.

The Scholarship of Community Engagement

Historical Context

Several forces have convened to create an atmosphere within academe that encourages researchers to pursue community engaged scholarship in health. Boyer’s (1990) examination of the role of scholarship within the professoriate laid the groundwork for broadening the definition of scholarship to include community engagement as a valued form of scholarship. As institutions and researchers expanded their scholarship to include community engaged scholarship, formal recognition of its importance occurred.

The creation of the Carnegie’s Community Engagement Elective Classification in 2006 was designed to recognize and elevate the value of community engaged scholarship. It recognizes elements of universities’ community engaged scholarship that are not acknowledged in Carnegie’s Basic Classification system. The Community Engagement Elective Classification recognizes academic and community collaborations that benefit

both the community and the academy. Specifically, the partnerships category elevates scholarship that is based on “collaborative interactions with community and related scholarship for the mutually beneficial exchange, exploration, and application of knowledge, information, and resources” (The Carnegie Foundation for the Advancement of Teaching, 2010, n.p.). The Community Engagement Classification was introduced in 2006 with 76 colleges and universities selected as institutions of community engagement (Driscoll, 2008). As of 2010, 196 universities have attained the classification (The Carnegie Foundation for the Advancement of Teaching, 2010). Unlike the Carnegie Basic Classification that relies on national data, colleges and universities must go through an extensive application process in order to become designated as community engaged institutions. The documentation includes presenting evidence of a commitment to community engagement in their stated mission and strategies. Further, the institutions must document a history of allocating resources to accomplish the community engagement aspects of their mission (Driscoll, 2008). University/faith community partnerships are one form of community engagement that helps fulfill the requirements for documenting community engagement.

Another significant source of influence for the community engaged scholarship specifically in health has been the creation of Clinical and Translational Science Awards by the National Institutes of Health in 2006. The CTSA model has five strategic goals with improving the health of our communities and the nation as the fourth goal (Clinical and Translational Science Award [CTSA] Consortium’s Community Engagement Key

Function Committee and the CTSA Community Engagement Workshop Planning Committee, 2009). Each strategic goal has key functions attached to it. One key function aligned with the goal of improving community health is community engagement. Institutions that have achieved designation as CTSA must actively pursue community engagement for health, further legitimizing and supporting community engaged scholarship.

Evidence of the impact of these initiatives to promote community engagement may be seen in the number of papers published related to community engagement for health. During the period from 1990 to 1999, a search of PubMed for “community engage*” yielded 313 results. The same search for the period from 2000 to 2010 yielded 1449 papers. A similar search using “community partner*” provided two and 20 results, respectively. The growing recognition of CBPR is demonstrated by its recognition by the Institutes of Medicine (IOM) as one of eight content areas for training in schools of public health (Gebbie, Rosenstock, & Hernandez, 2003). The increasing pace of community engaged scholarship for health underscores the need to study the formation of partnerships for health research. This research has been designed as an extension of the work in the scholarship of community engaged research. For the purposes of this study, the term *researcher* is used in the context of academic researchers who are affiliated with an institution of higher learning.

Community-engaged research has been conducted with a broad range of community partners across the spectrum of research activities. Community partners may

be involved in the initial phase of a research partnership development including identifying health issues to be researched, grant administration, and preparation proposal development (Corbie-Smith et al., 2010; Dobransky-Fasiska et al., 2009). Moreover, community partners may participate in elements of the conduct of a study such as research design, participant recruiting, data collection and analysis, reporting findings, and co-authorship (Baiardi, Brush, & Lapides, 2010; Castleden, Morgan, & Neimanis, 2010; Corbie-Smith et al., 2010; C. J. Jackson, Mullis, & Hughes, 2010; Javier et al., 2010). Faith community partners, as one type of community partner, may be involved in any or all of these research activities.

Community-based Participatory Research

Community-based participatory research is a widely recognized and utilized framework for health promotion research, although it is but one form of community engaged research. Community engaged research occurs across a spectrum of engagement from community-placed to community-based participatory research.

Corwall and Jewkes (1995) present a four-level model of participation that is similar to the continuum of community engagement. Figure 1 illustrates the connection between the continuum of community engagement and the modes of participation model. It places the level of participation from least to most participative. In the contractual mode participation is limited to an agreement to be research subjects. The second level, the consultative mode, is an arrangement in which people are asked for their opinions on

the research prior to execution of the intervention. Researchers and community members work together on projects that are designed and managed by the university researchers in the collaborative mode. The final mode, the collegiate, resembles CBPR with researchers and community members working as colleagues for purposes of mutual learning and with community members in control over the process.

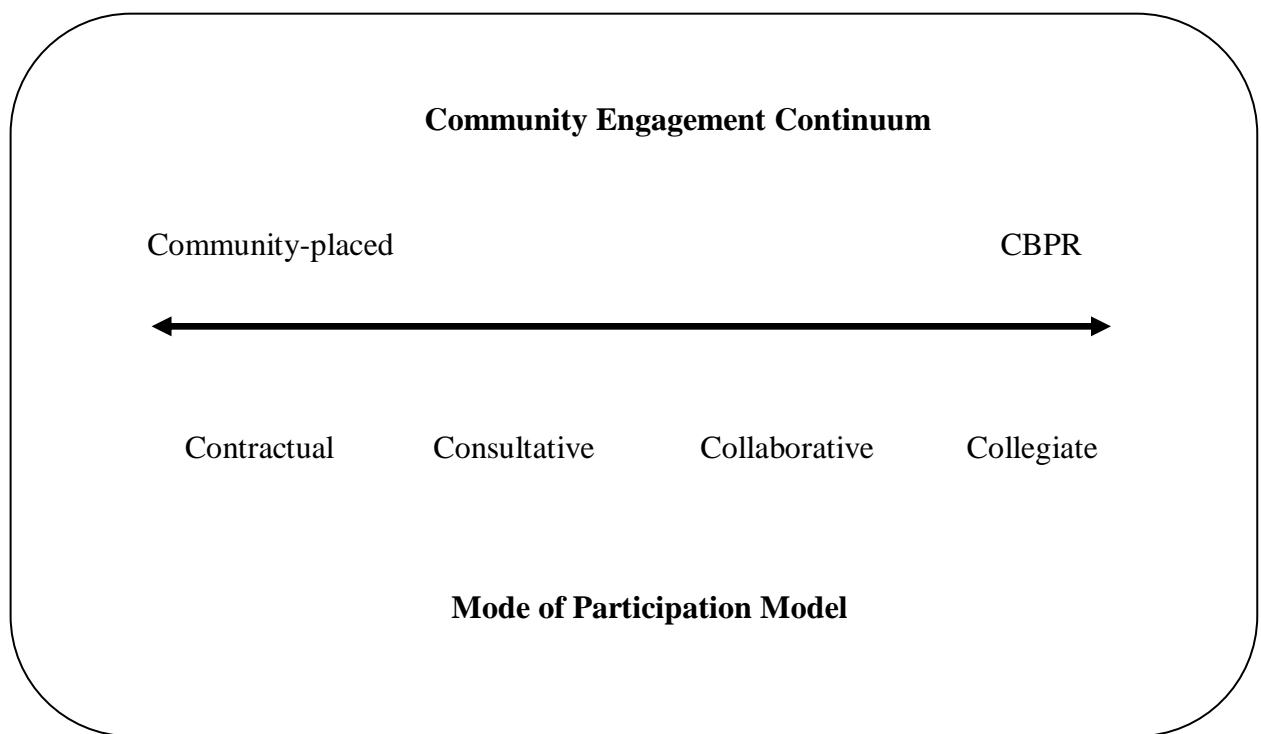


Figure 1: Community Engagement Continuum

Israel and colleagues (1998) in their seminal work on community-based research synthesized the literature on participatory approaches to research in public health. (At the time of this early discussion of community engaged research, the term community-based

participatory research had not yet evolved and Israel and her colleague's work lead to the development of the term. Their article outlines the principles that became the basis for CBPR.) They make a critical distinction between community-based research and conducting research in a community setting (community-placed research). This distinction echoes the description of community engaged research put forth by Ross in which the level of community engagement varies across a continuum from community-placed to CBPR (Ross et al., 2010). Community-placed research utilizes the community as a setting for research without any active involvement of the community members in the design or conduct of the research, employing a relatively positivistic paradigm for research. A foundational question of this research project will be to explore clergy preferences related to the extent of participation in the design and conduct of research in their communities for themselves and their congregation members.

The work of Israel et al. (1998) resulted in a coherent framework for engaging in community-based research. They outline the underlying paradigm for inquiry, key research principles, and challenges and facilitating factors in conducting community-based research. Community-based research eschews the positivistic paradigm of knowledge construction in which public health research was traditionally rooted (Israel et al., 1998). Positivism employed an approach to research based a static, singular reality. In positivism, the observer is considered to be independent from the situation being investigated. The observer is portrayed as value-free and neutral vis-a-vis the topic being investigated. According to Israel et al., the reliance of public health researchers on the

positivistic paradigm created separation between public health researchers and practitioners [or community members] by elevating the supposed objective knowledge of researchers over the experiential knowledge of practitioners [or community members].

Israel et al. (1998) propose that community-based research provides a means to bridge the gap between researchers and community partners through an approach to research that draws upon constructivism with its multiple perspectives of reality as well as critical theory with its incorporation of social, political, economic and other power dynamics in the research. This use of constructivism and critical theory paradigms with their emphasis on socially constructed knowledge fits well with community-based research since a “fundamental characteristic of community-based research...is the emphasis on the participation and influence of nonacademic researchers [community members] in the process of creating knowledge” (p. 177). While a complete review of constructivism and critical theory is beyond the scope of this work, Wallerstein and Duran’s discussion of the theoretical underpinnings of CBPR serves as a basis for this inquiry (Wallerstein & Duran, 2008).

Critical theory is foundational to CBPR in two areas—power differences in the relationships that form partnerships and the emancipatory traditions of CBPR. Power differences between community members and university researchers must be recognized and addressed in the construction of CBPR projects. Inadequate transparency about power differences and lack of open discussion regarding how those differences will be addressed may result in compromised design, implementation and evaluation of CBPR

projects (Wallerstein, 1999). The second area in which critical theory has influenced CBPR is in the purpose of knowledge creation. Wallerstein and Duran (2008) emphasize the emancipatory purpose of co-creating knowledge as university researchers collaborate with community partners. This is consistent with the fifth principle of community-based research—to “promote a co-learning and empowering process that attends to social inequalities” (Israel et al., 1998, p. 79).

Utilizing constructivist principles in CBPR may contribute to reducing power differences between university and community researchers. Constructivism assumes multiple, holistic realities (Rodwell, 1998). The use of emic language that provides an insider’s viewpoint is a principle of constructivist research (Rodwell, 1998). The process of incorporating the voices and language of the community into the research design, implementation and reporting may assist in shifting power from the university researcher to the community partners. Additionally, the cyclical and iterative nature of CBPR research echoes the hermeneutic circle methodology of constructivist research (Israel et al., 1998; Rodwell, 1998). The iterative process allows community partners to ensure that their realities are being accurately reflected.

This project draws on the constructivist and critical theory paradigms in keeping with the tenets of community-based research. From constructivism, the research will utilize an emic approach reflecting the voice of the participants whenever possible. Additionally, it will employ a critical theory perspective to explore the power dynamics of university/faith community partnerships.

CBPR is a framework in which research can be conducted. Israel et al. (1998) outline eight key principles of community-based research (later CBPR). The key principles of community-based research are envisioned as a continuum with each principle as a goal to be attained. The principles are:

1. Recognizes community as the unit of identity
2. Build on strengths and resources within the community
3. Facilitate collaborative partnerships in all phases of the research
4. Integrate knowledge and action for mutual benefit of all partners
5. Promote a co-learning and empowering process that attends to social inequalities
6. Involves a cyclical and iterative process
7. Addresses health from both positive and ecological perspectives
8. Disseminates findings and knowledge gained to all partners (Israel et al., 1998)

Israel and colleague's (1998) construction of these principles and ways in which they may be enacted in CBPR projects are outlined below. Recognition of communities as the unit of identity involves identifying communities—neighborhoods, families, churches, ethnic groups—with which to partner for research. Communities are not merely people living or working in proximity to one another. The people within communities hold a socially constructed shared sense of common identity, and fate. Communities construct shared norms, values and symbols. CBPR researchers recognize and respect the common cultural identifiers of the communities in which they work.

Communities like churches are organized with an established organizational structure, identified leaders and the ability to sustain themselves over time, therefore, enabling partnerships directly. However, unstructured communities (the “African American Community” or the “Homeless Community”) also are potential partners for CBPR. In these cases, university researchers may participate in an empowerment process. During this process the community develops the structure necessary, either through existing external resources such as a community-based organization or developing structures internally, to participate in research (Ross et al., 2010).

All communities have strengths and assets that can be incorporated into the design and implementation of CBPR projects (Minkler, 2005). CBPR researchers seek to recognize and support the community assets and social structures that are available to the communities to improve the health of their communities. However, Ross and colleagues (2010) caution researchers to be cognizant of the potential effects of engaging in health research in the context of community. The act of participation may cause tensions or conflict within the organization, thus endangering the social structures of the community the research aims to build.

Collaborative relationships are at the heart of community engaged research. The distinction between community-placed research and CBPR become stark as one examines the differences related to this principle. According to the principle of facilitating collaborative relationships in CBPR, if CBPR principles are completely incorporated into the partnership, community partners are equal members of the collaboration. They share

control in all phases of the research design, implementation, and evaluation. This includes problem definition, data collection and data analysis (Israel et al., 1998). Reaching this ideal is a complex endeavor requiring significant dedication of resources and effort on the part of the community, researchers and universities (Cornwall & Jewkes, 1995). Community and university partners bring differing skills to the partnership, and those differing skills contribute to the construction of the partnership arrangements.

According to Israel et al. (1998) integrating knowledge and action for mutual benefit of all partners in CBPR projects within communities may not always involve direct action toward changing the health issues that are the subject of the project. However, it does involve a commitment to utilizing the knowledge gained at some point to move toward changing the health behaviors or underlying causes of the health problem. The direct action may evolve from the dissemination of findings and knowledge gained to all partners. The findings and knowledge must be conveyed in ways that are accessible to all partners. In the faith community context, findings may be disseminated to community members through newsletters, sermons, bulletins or other existing communication methods. For example, Kaplan et al. (2006) found that some of the congregations involved in their CBPR project used the knowledge gained as a result of participating in the project to revamp church menus to incorporate healthier menu items.

CBPR as an approach to research explicitly recognizes the knowledge that communities possess and promotes a co-learning and empowering process. The power dynamics between academics and community partners who are often economically and socially marginalized are intentionally addressed (Minkler, 2005). The Bronx Health REACH project epitomizes a CBPR project in churches that addressed social inequalities through a co-learning and empowering process (Kaplan et al., 2006; Kaplan et al., 2009). The project invested significant time and effort in negotiating power sharing arrangements. Moreover, the objective of the intervention was to “educate church members about health promotion and disease management and to empower congregations to seek equal access to health care” (Kaplan et al., 2006).

The processes used to conduct CBPR projects are cyclical and iterative. CBPR is a time and labor intensive process that involves collaboration on assessing community needs and defining problems to be addressed through the project; developing methodology; data collection, analysis and interpretation; disseminating findings; and incorporating sustainability (Israel et al., 1998).

Finally, CBPR utilizes a positive, holistic model of health that includes not only physical health but incorporates mental and social wellbeing into its design (Israel et al., 1998). Additionally, ecological models of health that incorporate holistic definitions of health and social determinants of health are prevalent in CBPR designs (Baker et al., 2006; Campbell et al., 2007; Kaplan et al., 2006). Faith communities, as established entities within the broader society, may be well situated to conduct interventions that

address the various levels of ecological models---intrapersonal factors, interpersonal processes and primary groups (particularly families), community factors, and public policy (McLeroy, Bibeau, Steckler , & Glanz, 1988).

General Theories, Models and Characteristics of Health Promotion Research in Faith Communities

Theories and Models

Few researchers have developed and tested theories and models specifically related to university/faith community partnerships for health promotion (Baskin et al., 2001; Carter-Edwards et al., 2006; R. S. Jackson & Reddick, 1999; Ramsey, 2004). Several have described characteristics of successful partnerships without attempting to develop theories or models (Atkinson et al., 2009; Demark-Wahnefried et al., 2000; Kaplan et al., 2006; Laken et al., 2007; Rodriguez et al., 2009). The research that has examined university/faith community partnerships provides insight into the potential construction of such partnerships and provides guidance for establishing effective working relationships. The first four research studies presented in this section of the literature review examine attitudes related to health ministries in African American churches, a model of faith and health initiatives (both practice- and research-based), a model of cultural sensitivity for health initiatives in African American churches, and a framework for lasting collaborations (Baskin et al., 2001; Carter-Edwards et al., 2006; R. S. Jackson & Reddick, 1999; Ramsey, 2004). These studies speak to several issues—the

salience of participating in research partnerships from the perspective of clergy, potential elements of partnerships, cultural sensitivity in partnerships, and levels of trust and commitment required for successful partnerships. Perhaps the most notable feature of this section of the literature review is the paucity of literature directly related to model and theory development, thus demonstrating the need for continued scholarship related to models of university/faith community partnerships.

Among scholars, research is typically considered a worthy endeavor. However, it is necessary to determine if community members, specifically faith communities, consider participation in research a valuable investment of limited time and resources. In an exploratory survey of health ministries in African American churches, 98 clergy and lay leaders were asked to rate the perceived importance and the existence of health ministry attributes in their churches. The attributes were divided into four groups—(a) leadership and staffing, (b) function, (c) technology and funding, and (d) collaboration. The attribute group pertinent to this literature review is *collaboration* which is defined as “research partnerships with academic institutions and local community organizations such as health agencies, outreach programs and foundations” (Carter-Edwards et al., 2006). The survey utilized a three-variable scale—*not at all important*, *somewhat important*, and *very important*. The findings indicated that 23.6 percent of the churches had existing partnerships with university researchers and 41.7 percent of the survey respondents perceived that such partnerships were *very important*. The difference between the actual participation in partnerships with academic researchers and the

perception that such partnerships were valuable may suggest that opportunities exist for additional partnerships for health research. However, research partnerships require the commitment of limited church resources. Twenty attributes that each require a commitment of time and effort were considered. The researchers report the percentage of respondents who considered each attribute *very important*. The attribute “church participates in research studies with universities” ranked seventeenth of the 20 attributes measured. While the research has limitations with a small, convenience sample, the results suggest that research partnerships with universities may be considered valuable but they appear to be less of a priority than the implementation of health ministry programs in those churches. The research suggests that issue of salience of participating in research partnerships requires further investigation.

Ramsey’s (2004) grounded theory exploration of faith and health initiatives proposes a model of faith and health. The sample used to develop the model includes 10 different faith traditions among the Judeo/Christian faiths across 30 clergy interviews. Unlike Baskin, et al. (2001), Jackson & Reddick (2010) and Carter-Edwards, et al. (2006) who studied African American churches, Ramsey’s sample includes clergy from predominantly White congregations. Seventy percent of the sample was comprised of clergy from predominantly White congregations with the remaining 30 percent from predominantly African American churches. While qualitative research is not generalizable, the more diverse sample utilized by Ramsey suggests that the concepts

presented may be utilized to inform research in a wider faith community context than the other three models.

Ramsey's (2001) model integrates 10 constructs of working relationships between the public health community and congregations—(a) theological assets, (b) faith leaders, (c) history, (d) congregational assets, (e) congregation's faith, (f) physical organizational assets, (g) community needs, (h) congregational needs, (i) partnership, and (j) public health community. While the model is designed to encompass the full spectrum of health/faith initiatives, university/faith community partnership constitute one type of initiative. The model created through this study aligns with several of the key principles of CBPR—building on strengths and resources within the community, facilitating collaborative partnerships in all phases of the research, and addressing health from both positive and ecological perspectives. This alignment suggests that clergy hold a perspective of partnerships that is congruent with a CPBR approach. The constructs of theological assets, faith leaders, history, congregational assets, congregation's faith, and physical organizational assets are strengths and resources that faith communities bring to the partnership. The model identified assets unique to the faith community context—faith leaders, theological assets and the congregation's faith. Ramsey's findings related to the role of faith leaders will be discussed later. In Ramsey's model, theological assets are primarily brought to bear on health promotion through sermons and other communications to the congregation relating theological beliefs to health. The congregation's faith is portrayed as integral to their concept of healing. Ramsey's model

suggests that university researchers should consider incorporating the unique characteristics of faith communities—theology, leadership, and congregational faith—into the design of university/faith community partnerships.

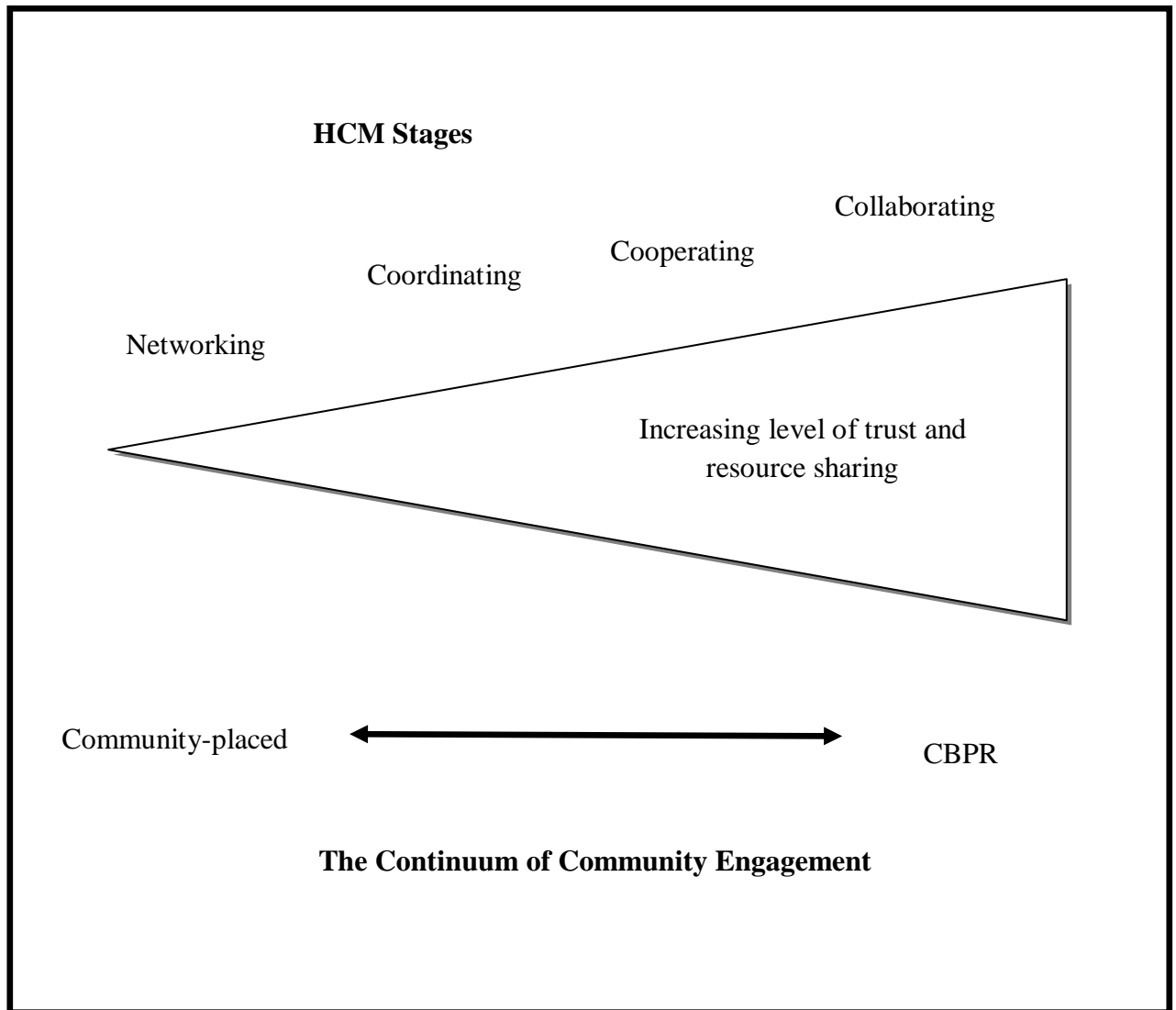
The ways in which researchers interact with faith communities can be explored on many levels. Baskin et al. (2001) approach intervention models through the lens of cultural sensitivity. As part of their work with three health interventions in African American churches, they developed a model of cultural sensitivity used to guide those interventions. It incorporates two dimensions—surface structure and deep structure. Surface structure involves utilizing messages and materials that were congruent with observable social and behavioral characteristics of the target population such as manner of dressing, food preferences, and music with which the target audience is familiar and comfortable. Deep structure “reflects the influence of cultural, social, psychological, environmental, and historical factors on health behaviors across racial/ethnic populations” (Baskin et al., 2001, p. 828). It includes the ways in which members of the target population perceive the cause and treatment of illness. Specifically, in a religious setting, deep structure reflected how faith, family and other social structures affect health behaviors. While Baskin’s (2001) model of surface and deep structures was specifically designed and tested in African American churches, it brings attention to the need to incorporate cultural sensitivity into the design of research projects conducted in faith settings.

University/faith community partnerships are established through a process of building trust and mutual effort. The Healthwise Project was a collaborative project between 12 African American churches and a local historically black university in North Carolina. The project was implemented for the purpose of improving the health of older African Americans (R. S. Jackson & Reddick, 1999). The partnership was developed in four stages represented in the model—networking, coordinating, cooperating and collaborating. Progression through the stages requires increasingly deeper levels of organizational commitment and trust. In each stage the activities are conducted for mutual benefit and to achieve a common goal. The networking stage is characterized by the exchange of information. The coordinating stage adds shared activities or altered schedules to the exchange of information. In the cooperating stage, the partners begin to share resources such as technical expertise, personnel or physical space. Collaborative relationships are characterized by a willingness on the part of both parties to enhance one another's capacity to reach the common goal and requires a significant commitment of resources and time.

The Healthwise Collaboration Model (HCM) serves to inform this research through its delineation of stages of interaction through which campus/church partnerships may progress. Community-placed research interventions may require the networking or perhaps the cooperating stages of the HCM. A partnership that intends to execute a fully-functioning CBPR intervention involves a collaborative relationship. The HCM did not explore preferences about which stage of partnership involvement was preferred by the

faith communities. Placing the HCM with its increasing levels of trust and commitment in the context of Carter-Edwards et al. (2006) makes this question relevant to the proposed research (Figure 2). Resources are limited and faith communities must make decisions regarding the expenditure of those limited resources. Carter-Edwards et al. suggests that participating in collaborative research with university partnership may be valuable to faith communities. However, it also suggests that other health-related activities may be of higher priority to clergy. The relative value of various activities, both related to health and general ministerial duties, may determine clergy's preferred placement of research activities along the continuum of community-placed to CBPR.

Figure 2: Stages in the Healthwise Collaboration Model



Characteristics

Studies that examine the characteristics of effective partnerships present some common themes. These themes are (a) the role of pastoral leadership in health programs, (b) respect and trust between partners, (c) aligning program objectives with the church

mission, (d) utilizing strengths of the faith communities, and (e) cultural similarities and differences between the academic and faith communities.

The first theme is the importance of congregational leadership. In a qualitative exploration of the programmatic dimensions associated with a successful diabetes intervention, Atkinson and colleagues (2009) emphasize the importance of the endorsement and continued participation of church leadership in the partnership. The words of a participant in a study in the Bronx portray the sentiment well. “It must be the pastors who take the lead. The pulpit is raised up literally and figuratively—that word comes from a higher place” (Kaplan et al., 2006, p. 12). Additionally, they speak of the necessity of the pastor functioning as a champion for health messages and the program. Likewise, in reviewing the lessons learned in a fruit and vegetable intake intervention, recognizing and respecting the power of the pastor of African American churches is a key finding (Demark-Wahnefried et al., 2000). Two assessments of a health equity intervention in the Southwest Bronx not only echo the importance of clergy support but report that pastors felt they needed training and education from other pastors (Kaplan et al., 2006; Kaplan et al., 2009). This training is specifically intended to provide the spiritual context and references pertinent to the health messages clergy would deliver from the pulpit. In another study, pastors who participated in focus groups related to cancer education in church settings reflected the desire to have spiritual content related to the program come from their ranks rather than from the academic partners, unless the academic partners were members of the faith community (Rodriguez et al., 2009). The

frequency with which pastoral leadership, buy-in and participation are mentioned suggests that pastoral support is vital to any effective university/faith community partnership.

Trust and respect are recurring themes throughout the literature of university/faith community partnerships. Consistent with the CBPR principle of co-learning and creating knowledge through a cooperative process, Demark-Wahnefried and colleagues' (2000) findings indicate that open communication and spending time with congregations are critical to the establishment of trusting relationships. A physical activity intervention partnership with African American churches, demonstrates the importance of compromise in the designing of an intervention to address congregational concerns. Church representatives felt that a randomized trial in which some congregations were used as the control group and were not slated to receive the intervention was unfair. To address their concerns, the design was changed to provide a delayed intervention for the control congregations. The compromises made by the university investigators bolstered trust between the congregations and academic partners (Laken et al., 2007). These findings suggest that it is incumbent upon investigators to invest time in listening to the concerns of faith community partners and work together to find workable solutions that demonstrate respect for the community partners' concerns.

Findings from several studies suggest that the implications of differing organizational structures in academe and faith communities require attention, particularly during the formative stages of the partnership. Researchers indicate that respecting the

church mission and aligning the program with that mission is important (Atkinson et al., 2009; Demark-Wahnefried et al., 2000; Kaplan et al., 2006). As stated previously, congregational participation in research projects requires the commitment of limited congregational resources (Carter-Edwards et al., 2006). Proposed programs that align with the mission of the church may be viewed more favorably than those that do not make a contribution to the congregation's mission. Laken et al. (2007) suggest that the hierarchical structures of universities and churches may provide a common framework for organizing work. However, some significant organizational culture differences also exist. Program participants are generally volunteers and often are only available evenings and on weekends. Laken suggests that university investigators should recognize the operational characteristics of the faith communities and adopt a flexible approach to working relationships that accommodates the needs of the faith community members. Investigators should be available during hours convenient to the congregation members—primarily evenings and weekends. Second, investigators need to recognize the more informal information networks of faith communities (Demark-Wahnefried et al., 2000). Data regarding membership, attendance or other operational processes may not be available to researchers in forms with which they are familiar, and university partners may need to adapt their data gathering processes accordingly. These findings suggest that university investigators who wish to partner with faith communities should address the organizational similarities and differences in project design. CEnR projects may

benefit from an attempt to capitalize on similarities and address differences in the design of project proposals.

Finally, the research suggests that investigators should include, or at least take into consideration, the influence of umbrella organizations (Demark-Wahnefried et al., 2000; Simpson & King, 1999). These umbrella organizations may include denominational organizations or organizations designed for interdenominational cooperation. Cooperation from these umbrella organizations may engender support during the initial contact with individual congregations and support on-going collaboration.

The literature related to theories, models, and characteristics of university/faith community partnerships for health suggests a number of avenues of inquiry for this study to explore with faith leaders. Topics include (a) clergy's desired level of involvement and commitment, (b) trust and respect, the importance of health research to faith communities, (c) ways in which research may fit with the mission of the congregations and clergy's individual goals, (d) cultural sensitivity in developing partnerships and research design, (e) organizational similarities and differences between academe and faith communities, (f) the role of umbrella organizations, and (g) the incorporation of religious concepts in health programs.

Selected Literature—Health Promotion Initiatives in Faith Communities

Health promotion and disease prevention intervention research is often situated in faith communities (DeHaven et al., 2004). The studies selected for inclusion in this review of the literature, while not all-inclusive, exemplify a wide range of research conducted in faith community settings. They include the full spectrum of community engagement levels from community-placed to fully functioning CBPR interventions. The topics of the interventions address a wide variety of health issues and behaviors such as increasing physical activity, cancer education and prevention behaviors, HIV/AIDS prevention, diabetes, and cardiovascular disease. The diversity of the studies appears in the variety of research designs employed—randomized control trials, various qualitative methods including interviews, focus groups, and ethnography, pretest/posttest designs, and posttest only designs. Less variety is evident in the racial composition of the congregations in which the studies occurred. African Americans were the primary racial group targeted in 12 of the 15 studies presented. Hispanics were a targeted racial group for four of the studies. Whites were the predominant racial group in one study. The studies were also geographically diverse; they were conducted in rural and urban areas throughout the United States. Studies in which the role of clergy was specifically investigated will be presented in the next section.

For the purposes of this review, the studies are organized according to engagement level—community-placed, community-based and CBPR. The successive

levels of engagement suggest increasing commitment of resources and time on the part of the faith organization including clergy time and involvement.

Community-placed Research

Community-placed research generally uses community settings for only recruitment and implementation of the health promotion program. Two of the exemplar studies have been classified as community-placed research. Anderson et al. (2006) tested a model of social-cognitive determinants of physical activity in 14 churches in southwestern Virginia. A sample of 999 adults were recruited to test an internet-based program to affect eating and physical activity behaviors among church members. The investigators approached the participating churches through contacting the ministers of the respective congregations. The investment of time and resources of the church was limited. Church communication systems (i.e., bulletins, announcements and a mailing to congregants' homes) were used to recruit participants. Participants completed a baseline assessment including height, weight, and demographic and psychosocial characteristics. They were asked to wear a pedometer and record their physical activity for one week. The physical activity data were correlated with the psychosocial characteristics (physical activity beliefs, social support, self-efficacy, outcome expectations and self-regulation). The model explains 46 percent of the variance in physical activity among participants.

In a telephone counseling intervention designed to encourage mammography, Duan et al. (2000) used churches as a source of participants for their intervention. Thirty

churches were randomized to the intervention or control conditions. The intervention group received annual phone calls with an educational message and reminder (cue to action) to obtain mammography. Female congregants aged 40 and older were screened for prior mammography and separated into two groups—baseline adherent participants and baseline nonadherent participants. Assessment at one year indicated that baseline adherent participants maintained adherence and non-adherent baseline participants reduced nonadherence from 23 percent to 16 percent. The churches were involved in disseminating information about the program through their existing communication channels and part time peer counselors who were church members were hired by the project.

The two studies exemplify general trends in community-placed research that stand in contrast to the principles of CBPR. First, the designs were entirely investigator-driven; the churches had no input into the design of the studies. Churches were asked to provide resources such as access to members as research participants and the use of church communication channels to promote the programs and recruit participants. However, neither study indicated that the investigators reimbursed the churches for their time or effort. One way in which power can be manifested is through the distribution of resources. It seems that no effort was made to equalize the distribution of power in the form of funding in either of these projects. No indication exists that the churches received any compensation for their involvement. In CPBR, the community is the unit of identity. These interventions were focused on individual behavior change. The findings

do not discuss organizational or structural changes within the churches themselves or ways in which structural or organizational changes might influence behavior (i.e. exercise classes in the church). Finally, neither article mentions sharing the findings with the faith communities as would be the practice in CPBR.

Community-based Research

Community-based research appears to be more common in health promotion research in faith communities than community-placed research. In comparison to community-placed research, community-based research incorporates a deeper level of involvement of the community partners, greater sharing of resources and— in some cases of faith communities— incorporation of religious constructs into the design of the intervention. The studies included in this review address a wide array of health issues such as increasing physical activity, diabetes prevention and management, cancer prevention, and HIV/AIDS prevention. The methods are equally varied from qualitative inquiry to randomized controlled trials.

Bopp and colleagues (2007) conducted a qualitative study of physical activity in African American churches in South Carolina. They held eight focus groups with a total of 44 participants to explore the perceived influencers of physical activity, connections between spirituality and physical activity, and the role of the church in promoting physical activity. Representatives from the umbrella organization, the 7th Episcopal District of the AME church, participated on the Institutional Review Board that approved

the study and participated in developing the interview guide. Four major themes emerged from the data—(a) spirituality and health, (b) barriers to physical activity, (c) enablers of physical activity, and (d) desired physical activity programs.

Two of the studies in this review related to diabetes control (Boltri et al., 2008; Quinn & McNabb, 2001). Boltri et al. (2008) assessed the use of the National Institutes of Health (NIH)-Diabetes Prevention Program (DPP) in a church setting. The NIH-DPP was translated from an individual intervention into one suitable for groups in African American churches. The program was modified into a 16-week program with a group interactive process and incorporated prayer into each session. Fifty participants from one African American church in rural Georgia were identified. Participants' blood pressure, fasting glucose levels, height and weight were measured prior to participation in the program, upon completion of the program and six and 12 months post intervention. All measures show statistically significant improvement. The design has several limitations including a small sample size and no control group. However, it demonstrates feasibility of the intervention. Similarly, Quinn (2001) tested a program using lay health educators for weight loss in African American women ($n=39$) in three churches in Chicago. The program was part of a larger diabetes intervention. The intent was to assess the feasibility of using lay health educators to lead a weight loss course in churches. Each pastor was asked to nominate individuals to serve as lay health educators. Of the 31 women who completed the course, the average weight loss was statistically significant at 8.3 pounds ($t=3.85$, $P<.001$). The course content was delivered consistently across several fidelity

measures with all measures having a >90 percent consistency rate. Again, the small sample size is a limitation but the results suggest that lay health educators may be a viable method of administering weight loss programs in church settings.

Cancer prevention is a common subject for church-based interventions (Darnell, Chang, & Calhoun, 2006; Davis et al., 1994; Erwin, Spatz, Stotts, & Hollenberg, 1999; Holt et al., 2009; Lopez & Castro, 2006). Three studies have been included that exemplify the variety of methods employed, sample sizes used and different types of faith communities in which interventions can be tested (Davis et al., 1994; Holt et al., 2009; Lopez & Castro, 2006).

Davis et al. (1994) conducted a large study with 24 churches in the Los Angeles area and a total of 1,012 participants in a study of social influence on cervical cancer screening behavior. Thirteen of the churches were predominantly African American and 11 churches were predominantly Hispanic. Lay health leaders were selected in each congregation using an ethnographic assessment protocol developed by the primary author. The authors emphasize the necessity of securing pastoral support in the early stages of the program. The program included (a) training lay health leaders in methods of establishing social support such as child care and transportation, (b) education and on-site screening (Papanicolaou smears), and (c) promoting sustained cancer control activities by the churches. Forty-four percent of the women presenting for screening had not been screened in the previous two years and, thus, are classified as underserved. The results indicate that the project was successful in establishing leadership and social support for

cancer prevention. The participating churches invested significant resources—providing buses, child care and meals—to facilitate participation in the education and screening program. This suggests that minority churches may consider cancer control and prevention an important service to provide for their members.

Decision-making related to screening for prostate cancer is a complicated process requiring the consideration of numerous factors (Holt et al., 2009). Holt et al. (2009) compared spiritually-based and non-spiritually-based prostate screening education interventions using community health advisors as instructors in a “Sunday school class” setting. This intervention is an example of a small program in a faith-based setting. Forty-nine African American men from two urban churches participated in the program. The two churches were randomly assigned to the spiritually- or non-spiritually-based intervention. Surveys were administered to participants prior to the intervention and immediately post-intervention. The surveys assessed prostate cancer knowledge, previous screening history, beliefs, self-efficacy, perceived barriers to screening, preparation for decision-making, and accessibility and appropriateness of the intervention. Both the spiritually-based and non-spiritually-based programs were well-received and had similar positive outcomes. The differences between the programs were not statistically significant on most measures, and sufficient evidence does not exist to draw a conclusion about the relative effectiveness of one program over another. The small sample size may contribute to the lack of statistical power. Additionally, the

investigators did not examine the fidelity with which the materials were presented which may have influenced the outcomes of the programs.

One study focused exclusively on Hispanics and the determinants of program attendance and participation in cancer control interventions (Lopez & Castro, 2006). Lopez and Castro (2006) designed a culturally tailored program addressing breast and cervical cancer for Latinas in Arizona. Once again, the program used lay health advisors. In this case, the *Promotoras* were bilingual/bicultural women who were members of the congregations in which they served. Fourteen churches were randomized into a cancer control or mental health program which served as the control. The *Promotoras* delivered health education classes and promoted cancer screening activities. A telephone survey of Hispanic women randomly selected from the churches' rosters assessed participation in educational activities and screening behavior. The results indicate that lower acculturation levels combined with greater church attendance was associated with greater attendance at cancer education events. Additionally, greater program attendance was associated with higher levels of cancer prevention knowledge.

The final study presented in this section of the literature review explores HIV-related knowledge and stigmatizing attitudes in 22 African American churches (Lindley, Coleman, Gaddist, & White, 2010). Project F.A.I.T.H. (Fostering AIDS Initiatives that Heal) was initiated to reduce the stigma of HIV among African American faith-based organizations in South Carolina. It provided funding to 22 churches for HIV/AIDS education and awareness activities. Prior to implementation, 1,445 church members, 61

pastors and 109 care team members were surveyed to provide baseline data on HIV/AIDS knowledge and stigmatizing attitudes. Surveys were administered by care team members to parishoners and the research team surveyed the pastors and care team members. The survey results indicate an overall low level of HIV-related stigma but males and older parishoners (\geq age 65) had lower levels of knowledge and higher HIV-related stimatizing attitudes. Knowledge levels of HIV transmission were generally high with the exception of ways in which transmission does *not* occur such as through casual contact, mosquitoes, donating blood and HIV testing. Pastors had higher levels of knowledge and lower levels of stigmatizing attitudes than their parishoners.

This study points to one factor of partnerships between health promotion researchers and faith communities that warrants further investigation. Nearly one of every four respondents to the survey expressed a view of HIV/AIDS that reflected a belief that sexual promiscuity is sinful and that HIV/AIDS may be a consequence of that sin. The investigators label this “victim-blaming” and consider it an attitude that warrants interventions to change. To the investigator’s knowledge, no explorations of the implications for partnerships of differing values between the faith community and public health community has been done.

Community-based Participatory Research

Two of the exemplar studies addressing breast and cervical cancer were conducted in African American and Hispanic churches (Darnell et al., 2006; Matthews et

al., 2006). Darnell et al. (2006) utilized a CBPR approach to examine mammography behaviors in 1,115 women in 17 African American and Latino churches in Chicago. Faith community members served on a Steering Committee. The Steering Committee members performed two primary tasks—designing an intervention strategy and administering surveys. The intervention used a standard breast health education curriculum in English and Spanish. Surveys were administered at the end of the intervention. The findings show that exposure to a church-based breast health program has the potential to increase screening behaviors, particularly among African American women. African American women in the study had higher rates of screening than Latinas, 72 percent and 41 percent respectively. Additionally, African American women were more knowledgeable about breast health than Latinas.

Matthews et al. (2006) worked with nine African American churches. They performed a qualitative evaluation of a faith-based breast and cervical cancer screening intervention delivered through a train-the-trainer model. Lay health advisors were chosen by the pastors of the churches to present the educational materials and arrange other breast and cervical cancer intervention activities. A survey was conducted to assess changes in knowledge and screening behaviors. The results of the survey are presented elsewhere. This article presented the findings of nine focus groups with a total of 94 participants. The focus groups examined perceptions about the effectiveness of various intervention components in increasing awareness and promoting screening behaviors. Key findings related to (a) the role of the church in health promotion, (b) awareness and

knowledge of the programs, (c) the effectiveness of the curriculum and educational activities, and (d) screening behaviors. The findings relevant to this research relate to the role of the church and clergy in health promotion. The participants perceived the church as an appropriate venue for health information dissemination. Ministers were perceived as important to the health education process through influencing perceptions of health and behavior and serving as a spokesperson for change. Personal testimonials, a common practice in African American churches, were a highly effective cue to action for screening.

The third study included in this review evaluated physical activity among African American church members in 20 randomly selected AME churches throughout South Carolina (Wilcox et al., 2007). The initiative was designed by partners from the University of South Carolina and the 7th Episcopal District of the AME church. Volunteers from the churches were trained to deliver a physical activity intervention in their respective churches. The program was a randomized controlled design with delayed intervention for the control churches because the AME considered randomized designs in which some churches did not receive the program unfair. Evaluation was conducted by telephone survey of 889 church members at baseline, one year and two years post-intervention. The intervention did not increase moderate physical activity among either members of the initial or delayed intervention groups ($p=.08$). The lack of significant change as a result of the intervention was addressed through a participatory approach.

Church leaders discussed ways to modify and more fully engage local church leaders the program to address the issues identified through the evaluation.

The studies outlined in this section of the literature review suggest some commonalities across levels of engagement. Several studies point to the importance of spirituality or religion and their influence on health (Bopp et al., 2007; Holt et al., 2009; Lindley et al., 2010; Matthews et al., 2006). All studies that used a randomized design conducted the randomization at the church, rather than individual, level (Anderson, Wojcik, Winett, & Williams, 2006; Duan et al., 2000; Holt et al., 2009; Lopez & Castro, 2006; Matthews et al., 2006; Wilcox et al., 2007). The amount of church resources expended to conduct the programs appears to increase as the level of engagement moves across the continuum from community-placed to CBPR. University investigators in community-placed projects used human resources such as lay health advisors and clergy support in the design of programs. CBPR required more church resources for designing and executing interventions both at the individual congregation and umbrella organization levels. For those studies that explored the influence of religion or spirituality, several indicated that religion and spirituality are influencers on health beliefs and behaviors (Bopp et al., 2007; Lindley et al., 2010; Lopez & Castro, 2006; Matthews et al., 2006). Holt et al. (2009) was the exception in finding that spiritually-based and non-spiritually based prostate cancer decision-making education did not produce significant differences.

Role of Clergy in University/Faith Community Partnerships

Specific inquiry into the role of clergy in university/faith community partnerships is limited (Ammerman et al., 2003). Several studies explore the role of clergy in university/faith community partnerships as a part of a broader work (Francis, Lam, Cance, & Hogan, 2009; Kaplan et al., 2006; Kaplan et al., 2009; Markens et al., 2002; Ramsey, 2004). These works provide significant insights into the role of clergy in university/faith community partnerships. Ammerman et al. (2003) specifically explore the expectations of African American clergy in a CBPR cancer and nutrition project. Pichert and colleagues (2006) describe an effort to prepare clergy for faith/health partnerships through a “Faith and Health” course offered at a predominantly African American seminary in Nashville. These studies, in conjunction with others discussed in previous sections, combine to suggest a direction to explore in delineating the potential roles clergy might play in university/faith community partnerships. These roles include (a) respected partner with knowledge of the congregation’s unique needs and situation, (b) recruiter/respected gatekeeper, (c) endorser, (d) role model, (e) theologian, (f) motivator, (g) informer/bridge to the community, (h) consultant on study design, and (i) change agent.

Partnership Development

Clergy function in a unique organizational position in which they are acutely aware of the health issues affecting their congregations (Pichert et al., 2006). They are

often called to serve as counselors to congregants who are experiencing health challenges (Ramsey, 2004). As such, during the formation of university/faith community partnerships they have the potential to contribute significant insight into the selection of health issues to be studied, congregational attitudes and concerns related to those issues, and methods of addressing those issues that will be culturally appropriate. Ammerman et al. (2003) surveyed congregational leaders in African American churches that had participated in a cancer and nutrition CBPR project. They asked leaders about the importance of church leaders and boards being involved in planning and decision-making in university/church partnerships. The findings indicated that 82 percent of pastors considered involvement either very or extremely important.

Clergy serve as a point of entry to the congregation. Ammerman et al. (2003) state that the pastor's "introduction and endorsement of a program to his or her congregation is essential" (p. 1720). Ramsey (2004) and Markens et al. (2002) identify recruiter or respected gatekeeper as an important function for clergy to perform in partnerships. Initial contact with a congregation is typically performed through approaching with the pastor (Davis et al., 1994; D. M. Griffith et al., 2010a; Kaplan et al., 2006). Studies that utilized lay health advisors uniformly approached the pastors of the churches to identify the individuals who would best fit that role (Davis et al., 1994; Demark-Wahnefried et al., 2000; Quinn & McNabb, 2001; Rodriguez et al., 2009). As the acknowledged spiritual leader of the congregation pastors hold a unique position to grant access and identify assets.

Another role pastors can assume during the early stages of a partnership is as a consultant on the design of the study. Ammerman et al. (2003) paid a pastor to serve as a consultant. However, it appears that it is more common for clergy to assume a consultant role on a voluntary basis (Bopp et al., 2007; Kaplan et al., 2009; Rodriguez et al., 2009). Ramsey's (2004) findings related to the role of clergy identifies informer as a role in which clergy see themselves. Clergy emphasized the importance of becoming aware of community needs. The role of informer is one who provides the congregation with information about health needs in the community in which the congregation is situated. Similarly, Francis (2009) describes the role of clergy as one that identifies community issues and issues of concern to the congregation. Once again, the unique position and perspective of clergy in faith communities allows them to serve in a position that uses their knowledge to enhance partnerships' potential for success.

Implementation

Once implementation of a program has begun, clergy may assume several other roles that enhance the success of the program. The literature suggests that clergy serve as role models, motivators, theologians of health, and change agents. Ramsey's (2004) model included role model and motivator as a clergy functions in health promotion partnerships. Clergy serve as role models through personal behaviors and direct interactions (counseling sessions). As discussed earlier, Atkinson et al. (2009) and Kaplan (2009) affirm the importance of clergy as respected role models and motivators.

Clergy are critical in encouraging congregational participation in health promotion programs (Demark-Wahnefried et al., 2000).

Research suggests that pastors can enhance health promotion interventions when they serve in the capacity of a theologian who connects health messages with spiritual principles. In the Nashville REACH 2010 program, researchers discovered that pastors of African American churches were often unprepared to support health interventions because they lacked a theological foundation to connect health issues with the churches' theological beliefs (Pichert et al., 2006). In response, a seminary course entitled "Faith and Health" was developed at the American Baptist College, a four-year Bible college serving predominantly African American students. Their findings indicate that pastors felt ill equipped to discern among research opportunities being offered their congregation because of a lack of understanding of the connections among health issues and spiritual issues. Ramsey (2004) also identifies the role of theologian as one that clergy assume in partnerships. An appropriate respect for and linking of health messages with spiritual content is suggested to enhance participation in health promotion interventions (Demark-Wahnefried et al., 2000). The role of theologian is one in which clergy expect university investigators to defer to clergy unless the investigator is part of the congregation (Rodriguez et al., 2009).

The final role the literature suggests clergy assume is that of change agent (Matthews et al., 2006; Pichert et al., 2006; Wilcox et al., 2007). Students in the "Faith and Health" course indicated a desire to serve as change agents in their respective

congregations (Pichert et al., 2006). Pastors participating in focus groups related to a breast and cervical cancer screening intervention indicated that they perceive that they should assume the role of spokesperson for change in their congregations.

Additional Relevant Literature

Research has a temporal dimension. Knowledge is constantly advancing and that is the case in this area of inquiry as well. This study was built upon the literature as it existed in August 2010. At that point in time, the literature that served as the justification for this study did not include any specific efforts to develop theory related to clergy roles in health promotion research partnerships. However, in September 2010, the first such attempt known to this researcher was published (Corbie-Smith, Goldman et al., 2010). Corbie-Smith and colleagues published research in which they used a grounded theory approach to exploring the roles African American clergy members might assume in health disparities research conducted in their churches. Corbie-Smith et al. identified 11 roles—(a) leader, (b) role model, (c) informant, (d) bridge, (e) spokesperson, (f) resource builder, (g) empowerment specialist, (h) collaborator in study design, (i) organizational gatekeeper, (j) sanctioner, and (k) protector. The similarities and differences among this study and the Corbie-Smith et al. study are outlined in Chapter 5.

Summary

Numerous roles have been suggested for clergy to assume in partnerships with university investigators. These roles include (a) respected partner with knowledge of the

congregation's unique needs and situation, (b) gatekeeper and point of entry to the congregation, (c) recruiter and endorser, (d) role model, (e) theologian, (f) motivator, (g) informer/bridge to the community, (h) consultant on study design, (i) change agent. However, no attempts have been made to develop a coherent theory or model of clergy participation in university/faith community partnerships. This research project will also explore the clergy's preferred level of engagement in research. In addition, it will examine which health issues they consider to be the most pressing concerns for their congregations. Finally, it will explore the clergy perspective of the benefits and barriers to participation in research. This research is intended to generate a grounded theory of the role of university/faith community partnerships that integrates the clergy perspective of partnerships into a coherent theory.

CHAPTER 3

Type of Study

This research project was designed to develop theory related to clergy members' perceptions of the roles they might play in university/faith community partnerships for health promotion research. Therefore, it is important to develop an understanding of the nature of theory and ways in which it can be developed. Theory "denotes a set of well-developed categories (themes, concepts) that are systematically interrelated through statements of relationship to form a theoretical framework that explains some phenomenon" (Corbin & Strauss, 2008, p. 55). The phenomenon in question in this project is the clergy's perceptions of the role(s) they may assume in partnerships between university researchers and faith communities.

Inquiry can be approached through two basic methods. The investigator may employ quantitative methods that emphasize "numbers, measurements, deductive logic, control and experiments" (McMillian, 2008, p. 10). Alternately, the investigator may choose to use qualitative methods. Qualitative methods involve an approach in which the researcher is situated in the environment. The investigator functions as an observer who utilizes interpretivistic and naturalistic methods to gather and inductively analyze data (Denzin & Lincoln, 2003). The two research methods may be used to accomplish different goals. In relation to theory, quantitative methods are used to test theory. Qualitative methods can be used to develop grounded theory (Bogdan & Biklen, 1982).

Rationale for Grounded Theory Research Design

Grounded theory is a method of research that aims to “generate, discover, or construct a theory that is an abstract analytical schema of a process or action or interaction” (Liamputtong, 2009, p. 206). Grounded theory is a useful research design when no theory exists as is the case in this research (Liamputtong, 2009). This project contributes to the field through the development of a theory that can be used to guide the formation of the clergy role in university/faith community partnerships for health research. Models and theories exist that are related to role formation but no specific theories exist related to the process of role formation (Carter-Edwards et al., 2006; Ramsey, 2004). The theory may provide guidance to the process of negotiating roles in partnerships that produce arrangements that support productive research while respecting the multiple responsibilities carried by clergy in the conduct of their daily responsibilities.

Grounded theory may be approached from numerous epistemological traditions. However, the three most commonly used approaches are those proposed by Glaser, Strauss and Corbin, and Charmaz (Liamputtong, 2009). Glaser’s approach originates in positivism while Strauss and Corbin adopt a pragmatic epistemology (Morse, 2009). Charmaz based her approach to grounded theory in a constructivist epistemology (Charmaz, 2006). However, all three major camps have three principles in common—(a) theoretical sampling, (b) constant comparison of data with theoretical categories, and (c) developing theory through the theoretical saturation of categories (Liamputtong, 2009).

The design employs theoretical sampling of clergy. Corbin and Strauss (2008) define theoretical sampling as “a method of *data collection based on concepts/themes* derived from data. The purpose of theoretical sampling is to collect data from places people, and events that will *maximize opportunities to develop concepts* in terms of their properties and dimensions, uncover variations, and identify relationships between concepts” (p. 143, italics mine). Unlike sampling methods used in quantitative research in which samples are chosen for generalizability and representativeness, theoretical sampling has as its objective selecting a sample that leads to the full development of concepts and theory (Liamputtong, 2009). Participants were chosen based on their anticipated contribution to the development of categories as well as their contribution to thick description of categories (Glaser & Strauss, 2007).

The participants consisted of 10 clergy members whose congregations have been approached to participate in a health promotion research study. Both clergy whose congregations accepted the invitation and those who declined were eligible to participate in order to generate a broad range of responses. Two participants had been approached and did not participate in the research. However, the interviews revealed that the lack of participation was not a result of a deliberate decision not to participate but not responding to an invitation to participate. In both cases, the pastors did not remember being approached although the investigator documented at least two attempts to contact each of the pastors.

Grounded theory is one form of qualitative research that is particularly well-suited to theory development because of its use of constant comparison (Glaser & Strauss, 2007). Grounded theory uses an inductive approach to analyzing data in which the theory emerges from the bottom up as disparate pieces of data are connected throughout the analysis (Bogdan & Biklen, 1982). Constant comparison is a feature of grounded theory data analysis in which each new piece of information is compared to previous data to generate constructs. Glaser and Strauss (1967) state that constant comparison “facilitates the generation of theories of *process*, sequence, and change pertaining to *organizations, positions, and social interaction*” (p. 114, italics mine). Role development and definition are constantly evolving in partnerships such as university/faith community research activities. CBPR is, by definition, a participatory process in which roles and responsibilities of the collaborating organizations are developed during the construction of the project. Therefore, grounded theory provides an appropriate method of inquiry for this project.

Theoretical saturation of categories is based on creating fully developed categories from the data (Strauss & Corbin, 1998). Sampling in quantitative research design is constructed to ensure representation of a population. However, in grounded theory where theory is developed inductively, “the concern is with representativeness of concepts and how concepts vary dimensionally” (Strauss & Corbin, 1998). The design of this project included a second round of interviews in which emerging categories were explored with the participants to add more depth to categories.

Research Questions

1. What are faith leaders' perceptions of the most important health issues to be researched?
 - a. What are the sources of these perceptions?
2. How do faith leaders envision a partnership between faith communities and health promotion researchers to be structured to address the most pressing health concerns facing their congregations and communities?
3. What do faith leaders perceive as their role in health promotion research?
 - b. What are the benefits of assuming this role?
 - c. What are the barriers to assuming this role?
 - d. How could they more effectively perform this role?

Overview of Procedures

The research was conducted in two phases. An initial interview protocol and demographic survey were reviewed by a panel of experts who provided input on the interview protocol and survey design. The information gleaned from this phase was utilized to refine the protocol and survey for the actual interviews. Data collection and analysis were conducted in an iterative fashion so that each successive interview informed the remaining interviews.

Participant Selection

Participants

Clergy faith communities from Judeo-Christian faith traditions were invited to participate. The potential pool of participants has been limited to clergy from Judeo-Christian faiths because the preponderance of health promotion interventions are conducted in Judeo-Christian houses of worship. For example, only 3.5 percent of all social services are delivered in non-Christian settings (Dehaven, 2004).

The Department of Health and Human Services sets public health objectives for the nation every 10 years. Healthy People 2010 had two overarching goals. The first was to increase quality and years of healthy life. The second was to eliminate health disparities (U.S. Department of Health and Human Services, 2001). Significant disparities in health status exist along racial/ethnic lines for most health conditions including cancer, cardiovascular disease and obesity (Smedley, Stith, & Nelson, 2003). Health disparities are particularly pronounced between African Americans and Whites. African Americans experience poorer health status than Whites in virtually every measure of health resulting in lower life expectancies for both males and females (Franks et al., 2006). As researchers looked for ways address the situation, working in African American churches became a reasonable avenue to pursue. The preponderance of health promotion interventions conducted in faith communities have been conducted in predominantly African American churches (DeHaven et al., 2004). However, health

disparities exist in other racial and ethnic groups and an increasing number of studies include underserved populations from other ethnic and racial groups (Duan et al., 2000; Kaplan et al., 2006; Kaplan et al., 2009; Simpson & King, 1999). The investigator attempted to include clergy from as varied racial, ethnic and gender groups as possible. However, as the recruiting process unfolded, the investigator could only locate clergy from studies targeting African Americans via predominantly African American churches. All participants are non-Hispanic, African American clergy from churches or umbrella organizations that are predominantly African American.

The design employed theoretical sampling of clergy. Participants were chosen based on their anticipated contribution to the development of categories as well as their contribution to thick description of categories (Glaser & Strauss, 2007). The investigator sought variation through clergy members from (a) a variety of ministry positions, (b) differing levels of previous involvement with health research, (c) different types of studies, and (d) interaction with three institutions of higher education. It was anticipated that ministry position would impact the participants responses through the demands of various ministry positions and the time commitments required to meet those demands. Both those who had extensive prior research experience and those who had none were interviewed. The two participants who had no previous experience had been approached to participate and had not done so. The researcher anticipated that their lack of participation was a deliberate decision. However, this was not the case leading to unanticipated findings that brought depth to the research. The two participants with no

prior research experience provided similar responses. Therefore, no additional inexperienced participants were recruited. The researcher anticipated that type of study would provide significant variation with clinical trials being viewed more negatively than health promotion research. Their experiences with health research include studies related to stress and prayer, breast cancer screening, diabetes education, health research ethics, and clinical trials. The type of study appeared to influence the responses but in ways that were unanticipated by the researcher. The type of study in which the participants had been involved contributed thickness to the data. They have worked with three different universities from the state in which they lived—the state’s flagship university, a land-grant institution, and a comprehensive university in a metropolitan area—adding thickness to the data. Each institution has had a different historical relationship with their surrounding communities and those relationships were mentioned by several participants. The institutions appeared to serve as a lens through which the participants created their perceptions of health research. Two participants had experience with more than one university and their responses suggested that exposure to multiple institutions expanded their perspectives.

The final participant pool included ten clergy members. All participants are African American and are affiliated with predominantly African American churches. The participants serve in congregations of various sizes. Congregational size, as well as outside employment status appeared to create diversity among the responses. Congregational size is presented in Table 3.

Table 3: Congregational Size

Congregational Size (Number of members)	Number of Congregations Represented
Less than 100	1
100-499	5
500-1,000	0
More than 1,000	3
Denominational Size (Number of Congregations)	Denominational Organizations Represented
1,100	1
1,500	1

Three faith traditions/denominations were represented. Eight participants came from Baptist churches, one was Methodist, and one pastored a nondenominational church that had strong ties to the Baptist tradition. Their job titles are summarized in Table 4. One participant holds two positions—one at the denominational level and the other at the congregational level. Two are Directors of Religious or Christian Education. Seven participants serve as the pastor of a single congregation. Two of the participants are from umbrella organizations. The Directors of Health Ministries both worked at the denominational level overseeing statewide health ministries. Eight participants work only in a single congregation. The various ministry positions held by the participants appeared to contribute to varied responses.

Table 4: Participant Titles

Title	Number of Participants
Director of Health Ministries	2
Pastor/Senior Pastor	7
Director of Religious or Christian Education	2

All participants had an educational level of college or higher. Advanced degrees are reported in Table 5. Additionally, Table 5 describes the participants' age, gender, employment outside of their roles in their churches or umbrella organization, years in ministry and years in their current roles. The participants had an average of 25.1 years in ministry and 11.9 years in their current role.

Table 5: Participant Description

Age	Gender	Highest Education Level	Employment Outside the Church	Years in Ministry	Years in Current Role
51-64	M	D.Min	no	20	5
51-64	F	D.Min	no	9	5
35-50	M	D.Min	yes, full-time	23	10
not reported	M	College	no	32	25
35-50	M	D.Min	yes, part-time	22	6
51-64	F	Ed.D	yes, full-time	26	16
35-50	M	M.Div, Th.M.	yes, part-time	30	16
51-64	M	M.A.	no	24	5
51-64	M	Ph.D.	not reported	40	26
51-64	F	M.Div.	yes, part-time	25	5

The existing qualitative research on clergy roles in partnerships for health is limited thus providing limited guidance as to an appropriate sample size (Kaplan et al., 2006; Kaplan et al., 2009; Markens et al., 2002). Markens et al. (2002) interviewed 16 clergy who had been involved with a CBPR breast cancer project. Ammerman et al. (2003) surveyed 44 lay leaders and 34 pastors regarding their perceptions of the participation in a cancer prevention/nutrition partnership with a local university. They conducted in-depth interviews with four pastors. Kaplan (2006) interviewed leaders of a

CBPR coalition designed to enhance knowledge of health promotion and access to health care. They interviewed 11 key participants who were coalition leaders and senior staff. In addition, they interviewed three pastors and three faith-based coordinators. While none of these studies were exclusively designed to assess clergy roles, their designs suggest that the interview sample size should be sufficient with five to 10 participants. Theoretical saturation began to emerge after the completion of nine interviews. The tenth interview was conducted to ensure saturation.

Recruiting Strategies

The potential pool of participants for this study was relatively limited since the number of clergy who have been involved with health promotion research projects is limited. The investigator conducted preliminary discussions with several sources that have connections within the local and state faith communities to assess the feasibility of recruiting a sufficient number of participants.

Recruiting for this study was conducted through a multi-pronged strategy. The investigator used personal contacts with members of various faith communities throughout the area to make initial contacts with clergy members on her behalf. This strategy led to five participants. Additionally, a researcher shared the clergy contact list from her study and the investigator contacted several pastors from that contact list resulting in interviews with three pastors. Finally, snowball sampling yielded two participants. One participant directly contacted a fellow clergy member in his city. The

second participant recruited through snowball sampling was contacted by the investigator.

Data Collection Strategies

Instrumentation

A semi-structured interview protocol was developed (Appendix A). The interview guide was constructed based on the research questions and elements of the role of clergy in faith community/university partnerships suggested by the literature. The interview protocol in Appendix A has the corresponding research question designated in the first set of parentheses after the question/probe. These elements include (a) clergy's desired level of involvement and commitment, (b) trust and respect, (c) the importance of health research to faith communities, (d) ways in which research may fit with the mission of the congregations and clergy's individual goals, (e) cultural sensitivity in developing partnerships and research design, (f) organizational similarities and differences between academe and faith communities, (g) the role of umbrella organizations, and (h) the incorporation of religious concepts in health programs. The elements suggested in the literature guided the construction of the interview guide. They served as points of departure rather than a set direction of inquiry (Charmaz, 2009). The way in which each element was connected to questions and probes is indicated in the second set of parentheses in the interview protocol in Appendix A.

The interview guide and demographic survey (Appendix B) discussed below was reviewed by a panel of experts prior to submission of the research protocol to the Institutional Review Board. The panel of experts consisted of a university researcher who has conducted health promotion research in faith communities, a researcher with significant qualitative expertise, and a member of the clergy. Each panel member received the interview protocol, the demographic survey and a draft first chapter of the dissertation as background via email. Panel members were asked to review and make comments on the protocol and survey. The investigator aggregated the comments and edited the interview protocol according to the suggestions.

Interviews

In-depth, in-person interviews based on a set of semi-structured, open-ended questions served as the primary data collection method following the approach to grounded theory interviews recommended by Charmaz (2006). Charmaz suggests that the interview format can range from a few broad questions to semi-structured interviews as long as the interviews are conversational and the participant is the primary speaker. The interviews occurred from February to July 2011. The interviews were conducted at a place and time of the participant's choosing. These places included participants' offices, church conference rooms, and a school lobby after a church service in the school. The researcher conducted the interviews. The interviews were based on a semi-structured interview protocol (Appendix A). A minimum of two rounds of interviews or other

communications with the participants were conducted with the exception of the last interview. That interview incorporated the emergent themes in the initial interview.

The emergent nature of the design for this study allowed the researcher to pursue themes that emanated from the data as they were collected. The first round of data collection were in-person, in-depth interviews. The second round provided an opportunity for member checking and for acquiring additional data related to emergent categories. Second round interviews were conducted in person, by phone or through email. Second round interviews began after the completion of the fifth first round interview. In person interviews were recorded and transcribed. Several themes emerged during the first five interviews that warranted further exploration. The themes summarized are summarized below. These themes formed the basis for the follow up interviews for the first five participants and were incorporated into the initial interviews for last five participants.

1. What impact, if any, does the focus of the research have on the decision to participate? Does it matter if the researcher is specifically focusing on faith communities or simply trying to access a particular racial or ethnic group via the church?
2. How do you feel about HIV/AIDS research in your church?
3. How do you feel about substance abuse research in your church?
4. How do you feel about mental health research in your church?

5. How do you think your congregants would react to these topics?
6. Could you tell me more about how the topic of health is related to your Christian beliefs and doctrines?
7. How does involvement in health research fit among the various priorities you have in *your position* at the church? How does it fit with the priorities of the *church as a whole*?
8. You expressed that the dimensions of holistic health were _____. Can you expand upon your definition of those dimensions? How do recognize health or lack thereof in those dimensions?

Appendix C presents the duration and methods for the interviews. Interviews were audio recorded and the interviewer took field notes. The field notes included participant responses to questions and the researchers' observations about the interview setting, as well as the participants' body language, intonation, and expressions.

Additional Documentation

A short survey of demographic information (Appendix B) was sent to the participants prior to the interviews. The survey included information about the clergy member and the congregation. Clergy questions asked for demographic information including age, race/ethnicity, gender, educational level and time in the ministry. The survey included three questions about the congregation—size, racial/ethnic composition and faith tradition or denominational affiliation of the congregation.

Supporting documentation was used as data in addition to the interviews. Supporting documentation included records pertaining to previous research experiences, church mission statements, theological or doctrinal statements, and congregational communications such as websites, bulletins and newsletters.

Data Analysis

Coding

The recorded interviews were transcribed and verified by the investigator. All participants were assigned a pseudonym and the details of their church or denominational organizations were masked to protect the identities of the participants. The interview transcripts and field notes were entered into NVivo 9 software for analysis (QSR International, 2010). Data was analyzed utilizing constant comparison in which analysis was conducted concurrently with data collection and the analysis informed the subsequent interviews and the follow up interviews.

In addition to the interviews, all other data such as transcribed field notes, website content, brochures, and other documents were entered into NVivo 9 and coded. An emphasis was placed on in vivo coding to use emic language in the development of the categories and concepts in the data (Corbin & Strauss, 2008). Data obtained from the surveys were entered into in NVivo 9 to allow searching and sorting of responses on the variables provided in the survey (i.e., age, education, or years of experience).

The data analysis included both open and axial coding. Data analysis began with open coding. Open coding is ‘breaking data apart and delineating concepts to stand for blocks of raw data’ (Corbin & Strauss, 2008, p. 198). The analysis incorporated axial coding into the analysis as soon as categories or concepts that relate to one another begin to emerge. Categories and concepts began to emerge after the third interview and continued to emerge through the eighth interview. The nodes and coding statistics are presented in Appendix D. In total, 1,129 data units were assigned codes.

Axial coding relates concepts or categories to one another, delineating relationships between concepts and categories (Corbin & Strauss, 2008). In the initial open coding phase, all codes were simply listed without any relationship or order. As themes began to emerge, codes were clustered into hierarchies (parent and child nodes). The parent nodes formed the categories that became major themes. In order to be included as a theme an idea had to be expressed by at least three participants. There are exceptions to this general rule. Only two denominational officials were interviewed. Any theme specifically related to a denominational or umbrella organization was included if mentioned by two participants. A second exception was used if one participant expressed a strong sentiment at least three times. Appendix E shows the relationship between themes and axial nodes.

Validity and Credibility

Grounded theory as one form of qualitative research relies on rigorous data collection and analysis techniques. McMillan and Schumacher (2006) discuss five strategies for enhancing validity in qualitative studies. These strategies are prolonged field work, multi-methods, verbatim accounts, low-inference descriptions, and negative case studies. Prolonged engagement in the field was accomplished through the initial in-depth interviews, follow-up interviews, documentation review, and attendance at church services and a denominational conference. Triangulation of data sources was used to add depth and credibility to the findings of the research through the use of the supporting data sources listed above. The extensive use of emic language created the use of low-inference descriptions. Emic language was used whenever possible to portray concepts and themes in the language of the participants. Some examples of emic language coding were *so what*, *guinea pigs*, and *make it easy*. Emic language allowed the data analysis and findings to reflect the language and meanings of the participants. In vivo codes were used to develop codes and categories for data that reflect participants' underlying meaning and assumptions (Charmaz, 1983). Data were reported in the participants own words with extensive direct quotes to preserve the emic language.

The researcher kept a reflexive log to identify and explore the influence of her constructions throughout data analysis. The reflexive log was a particularly important tool when exploring the participants' definitions of health and the underlying spiritual context of those definitions. It allowed the researcher to identify some areas in which her

own beliefs might have colored her perceptions of the participants' statements. For example, the researcher anticipated a deeper theological understanding of health than was presented by the participants. Reflection was helpful in processing the findings.

Reactivity was an issue that arose during the interviews. Reactivity is "the response of the researcher and the research participants to each other during the research process" (Paterson, 1994). While not using the term *reactivity*, participants viewed positive personal relationships with researchers as a necessary component of research. This expectation was expressed to this researcher. Several participants expressed appreciation for the researcher's willingness to listen. Dr. Walter's comments about the characteristics of a good researcher are typical of the expectations participants held. When asked if he had any final comments he would like to share with researchers he responded, "No, I think they should all be like you...you jumped right in there and came... I thought that was just great... You will find that we are very, very warm." Participants expressed that they felt heard and understood and, therefore, able to share freely. The researcher used the reflexive log to process her responses to the participants. Those reactions were positive and confirmed that the participants were open and warm as they stated.

The inclusion of both positive and negative experiences in university/faith community partnerships provided negative cases. Positive and negative cases were also reflected through the inclusion of participants who had prior research experience and those who did not.

Finally, McMillan and Schumacher (2006) recommend mechanical recording of data, member checking, and participant review. Data were audio recorded and the participants were provided the opportunity to review the transcripts for accuracy. One participant requested clarification of her interview.

Human Subjects Protection

This study protocol was approved by the Virginia Commonwealth University Institutional Review Board in compliance with human subjects protection regulations.

Delimitations

This study was limited to faith institutions from a Judeo-Christian tradition because the preponderance of the health promotion interventions conducted in faith communities have been conducted in Judeo-Christian churches (DeHaven et al., 2004). Additionally, the study was confined to investigating congregations who have been approached by health promotion researchers requesting that they participate in a health research project or clergy who have initiated a research study with health researchers. The pool of applicants was restricted to clergy who have at least been approached to participate in a research project. Two participants did not remember being approached to participate in a study. Their voices are an important element in soliciting maximum variation among the responses.

This project has been limited to those who have participated in health-related research projects. Faith communities may have been approached by researchers from other disciplines tangentially related to health such as education or social work but those research activities are beyond the scope of this investigation.

The term “faith community” may include any organization that has a faith component to it such as a YMCA or a faith-based social services agency (DeHaven et al., 2004). However, for the purposes of this investigation, faith communities have been defined in a narrower context that focuses on Judeo-Christian congregations. This narrow working definition of a faith community provided a more consistent environment for data collection and comparison. The theory arising from the data can be applied and tested in congregational settings.

CHAPTER 4

Introduction

The research leading to these findings was designed to examine (a) clergy members' definitions of health, (b) ways in which campus/faith community partnerships can be constructed to effectively conduct health research in faith communities, and (c) the roles clergy members envision themselves assuming in health research conducted in their churches.

Chapter 4 presented findings that are the product of ten in-person extensive interviews, nine follow-up interviews, and supporting documentation. Discussion and interpretation of the findings will be reserved for Chapter 5. Moreover, a descriptive model of the process of establishing clergy roles in health research will be presented in Chapter 5.

Most Important Health Issues to Research

This section addresses the first research question. What are faith leaders' perceptions of the most important health issues to be researched and what are the sources of these perceptions?

Pressing Health Issues to be Researched

The health issues that clergy members perceived as important were those that impact their parishioners and the surrounding community. All participants indicated a desire to study health issues that significantly impact African Americans. Table 6 presents the issues that participants indicated they would most like to see researched. The most often mentioned issues were (a) diabetes, (b) heart disease, and (c) cancer, particularly prostate cancer. Other issues that participants mentioned were HIV/AIDS, substance abuse, kidney disease, obesity, hypertension, and elder health.

Table 6: Pressing Health Issues to be Researched

Participant	Issues	Issue Statements
Rev. Edmunds	Weight Management Diabetes Heart disease Kidney disease	So what I would probably do is look at how weight management. (People don't like the word obesity). I would look at the role of, I would look at healthy living as a part of what it means to live a healthy life. Look at those various health conditions that disproportionately impact African-Americans. Diabetes heart disease, kidney disease, etc.
Rev. Burton	Heart disease Diabetes	Health preventive methods, healthy heart, diabetes. Those issues especially that dominate the African American community.
Dr. Walters	Obesity Hypertension High Cholesterol Diabetes Prostate Cancer	I would say that for our community--specifically the African American community--I think, that probably obesity, as I'm sitting here. And all those health related issues--high blood pressure, high cholesterol, and even diabetes. I think those are some health issues that stand out the most for us. Then I would say, you know, like we talk about

		men, this prostate, help them understand that even more.
Rev. Roberts	Prostate Cancer Diabetes Hypertension	I think more, perhaps, on prostate cancer, sugar diabetes and high blood pressure. I'd like to see more studies done with that because it seems that our congregation has dealt a lot with diabetes and, of course high blood pressure, blood pressure issues. And the men too. We've had quite a few of the men to have prostate cancer and even die from that.
Rev. Richardson	HIV/AIDS Cancer Diabetes	Because people for some reason have forgotten about AIDS. AIDS still exists. And I still bury people because of AIDS... Well, I guess every family is affected by cancer, if they admit it AIDS. And those are currently being researched. Just trying to get people to understand that these issues can be serious. Cause diabetes affects the woman more than the man.
Dr. Pierce	HIV/AIDS Substance Abuse Heart Disease Cancer	I'd probably want to extend, you know, work on HIV/AIDS and substance abuse...Heart disease, of course. And of course cancer is big right now.
Rev. Thomas	Diabetes Prostate Cancer Hypertension Heart Disease HIV/AIDS	Diabetes, prostate cancer, hypertension. Trying to think of what I deal with the most often. Vascular cardio issues...But I think that AIDS because we already have a ministry that is specifically geared toward dealing with education and advocacy. But the, for me, the top three would be diabetes, prostate and hypertension.
Rev. Lewis	Elder Health	"[The study would be] related closely to our senior population in as much as my congregants are mostly

		senior. That would be, that would be of interest, to the work as compared to what I would see is, you know, an area of concern that's kind of difficult to kind of put a hold on.
Rev. Allen	Diabetes Hypertension Obesity Substance abuse Cancer	Diabetes, hypertension, obesity, and substance abuse. And then I think about the preventive things as well... They did a colonoscopy of me on TV [laughter]. But we got good response. And we had ten people get colonoscopies. It was colon cancer awareness month and one of them had some cancerous polyps. So, every year we do that.
Rev. Douglas	Cancer Diabetes Proper Eating	It still remains cancer, a study about cancer, the importance of eating properly, getting your screening. That's still a need--a big part of it. The diabetes part of it.

The subtheme of issues that are sensitive to discuss in a faith context emerged during the first five interviews. During the follow up interviews with the first five participants and in subsequent initial interviews, participants were asked to specifically comment on issues that were sensitive or inappropriate to discuss in the church context. The research specifically inquired about researching the potentially sensitive issues of HIV/AIDS, substance abuse, and mental health. Universally, the respondents said that if an issue affected their population, it was an appropriate topic for research in their churches. However, their estimations of the receptivity of their congregations to these topics varied. Most respondents expressed that their congregations would be open to HIV/AIDS education. Dr. Walters described the response he anticipated from his

congregation to a study on HIV/AIDS. “So as a congregation, I don't think that as a congregation as a whole I don't think they would have a problem talking about that...I don't think we would have a problem with that because we're not that traditional. There are some traditional members, but not that traditional that we couldn't talk about something as serious as AIDS and talk about how it's transmitted.” Several already have existing HIV/AIDS ministries or programs. “Because even with our youth ministry here. There are certain subjects, because during the summer we have people from the...City Teenage Pregnancy Prevention come in. So we have the parents sign off. I have had some parents refuse to sign because they said they wanted to talk to their kids about sex. I said, ‘No problem’. ..Because it [HIV/AIDS] still affects everybody. Senior citizens are having sex and senior citizens are catching AIDS and other STDs so I don't see any subject [that would be inappropriate to address in the church setting].”

However, others felt HIV/AIDS research would not be well received. Rev. Thomas commented on HIV/AIDS research in his church saying, “Normally, sexual issues are the hardest to deal with.” Rev. Allen expressed that he felt his congregation would avoid HIV/AIDS research because HIV/AIDS is a fear-inducing topic. “I think people still have fear about that even in my church. And we've done a couple of AIDS things here. So it's I think they would, I don't believe they would even come for it. Even though we've buried a couple of people because of AIDS, although people didn't know. I knew because being pastor etc. But I think there's a fear.”

Substance abuse research was seen in a light similar to that of HIV/AIDS research. Ministries to address substance abuse appear to be common in the church and, therefore, a familiar issue. Rev. Richardson described these ministries. “Most churches either have AA or something, especially smaller churches that don't have large memberships. They still want to reach out to the community.” Rev. Roberts expressed his perception that it is the responsibility of the church to help people address substance abuse problems.

Well because it's one of the major issues in our society today. It's sort of their hope, for people who are hopeless, a lot of times they turn to drugs. And especially persons, many times, who are low economic status in society—meaning that they are using drugs and other needles. To me, we [the church] have to look at where the problems are and we have to deal with them without discrimination, who it is or why. But if there's a need to me we need to try to address it because it's a problem. And if nobody else does, we should.

Confidentiality was suggested as the key to a successful study on substance abuse. “I don't think it [substance abuse research] would be an issue. I believe as long as it's confidential. I don't think it would be an issue.”

Mental health research appeared to be an issue that most pastors believed would not be well received by their congregants. Rev. Burton expressed a typical sentiment in this area. “That [mental health] has a stigma. Folks would rather talk about sexually transmitted diseases, homosexuality in that context. But there is a stigma with mental health that we have not accepted that [addressing mental health issues in the church setting]. I don't think we're comfortable, with seeing mental health as being ‘crazy’. We don't see it in the context of depression and those things. We don't talk about it.”

Hamilton and colleagues (2006) found a stigma associated with participating in research about schizophrenia among African Americans. Similarly, Brown et al. (2010) found that among African Americans, the stigma connected to depression negatively impacted treatment-seeking behaviors. Rev. Lewis framed the reticence to discuss mental health issues as having its roots in historic and current racism. “As you know, mental health is really one of those kind of tough nuts to crack. And even more so in the African American community. It's very rarely discussed, talked about. There's no desire to want to talk about it. The mental health has its roots in of course, the historically and even current, institutional racism of our day.” The participants in a study of attitudes and beliefs about mental health among older African Americans shared this view that racism is a contributing factor to depression (Conner et al., 2010). They indicated that the day to day experience of discrimination and racism made African Americans more prone to depression.

Once again, Rev. Thomas was the voice expressing an alternative perception.

It's becoming more acceptable for folk to see mental health as not stigmatized. Because at one time, and you know I must confess personally I had similar issues in terms of dealing with the whole issue of therapy and that type of thing. But what I've seen--I've basically been in ministry 30 years--and in the 30 years I've seen not only the relevance of dealing with mental health issue but also how wide-spread it is. Not just in our population but in the population generally. In that there's no social taboo so to speak about going to see a therapist.

Dr. Pierce also felt that mental health research was possible in her church although it would require effort to convince her parishioners to accept it. She proposed a strategy to encourage acceptance of mental health research. “I think it [mental health research] has

to be. Research is always good. We haven't done anything in that vein... I'd probably put that cadre of counselors or persons to kind of be the core group if any research was going to be done in that area.”

Definitions of Health

The participants unanimously defined health in holistic terms. Nine participants specifically used the term *holistic*. Several participants began their definition of health using the term *holistic* in ways similar to these responses. “Probably in a holistic, holistic would be the word that comes to mind because health is more than just physiological. As a faith leader my focus of course is on the spiritual aspect of it. I recognize how the spiritual, mental, and physical go hand in hand.”

The participants’ notions of holistic health appeared to emerge from several sources. The participants delineated six dimensions and three characteristics of holistic health. The dimensions, sources, and characteristics of holistic health are discussed below.

Dimensions of Holistic Health

The participants described six dimensions of holistic health. Figure 3 depicts those dimensions. The six dimensions of holistic health appear to cluster into two categories—primary and secondary. The primary dimensions of holistic health are physical, mental/emotional, and spiritual. These dimensions are classified as primary

because they were mentioned by all participants. They were often referred to using the terms “body, mind, and spirit”. The secondary dimensions that were mentioned by some but not all participants are economic/financial, intellectual/cognitive, and social.

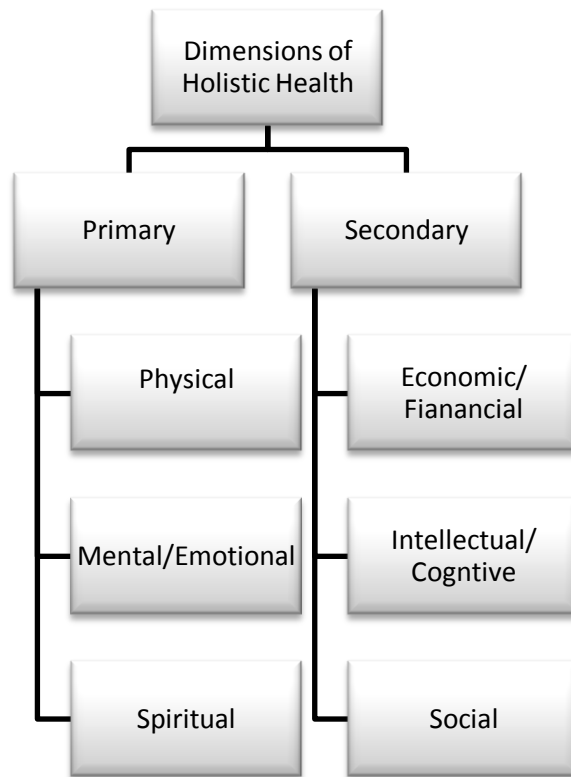


Figure 3: The Six Dimensions of Holistic Health

The participants viewed the dimensions of health as interrelated and interdependent. They expressed that lack of health in one area may lead to lack of health in other areas. Rev. Burton described the relationship between the various parts of a person as inseparable and interdependent in the healing process. “I think that if we do not approach the spirituality from the perspective that, in order to have a spirit, you have to have a body. So the body itself must be on one accord with the spirituality. If you are

not up to par physically, it is hard for you to concentrate on your spirituality. Your concentration will go more so on your physical well being... as opposed to a holistic approach of the body, soul and mind coming together for healing.” Dr. Walters spoke in similar terms about the connection between holistic health and his Christian beliefs.

I think, when we talk about health, I think from a Biblical perspective, salvation means wholeness. And I think that when we talk about health care we talk about helping people be whole, mentally, physically, spiritually, and emotionally. So, I see that faith, for me, and that's the point too, the whole work that goes into making us feel whole, giving us the confidence we need, health-wise... To me that's trying to do the right thing. Make the right decision... Sin to me, and this is my thing, sin is not just alcohol, drugs, liquor. But sin could be, if you want to look at it that way, too much sugar, too much salt, too much meat. Things can affect our wholeness. So to me, I see the Christian faith or Christian belief as being a kind of discipline where we try to live our lives in a way that helps us to be balanced. I think that's the word. Balanced. Which then helps us to be, to not be addicted to things. But to be able to live peacefully, live harmoniously with others. And to be able to feel good about ourselves. Having the dignity every human being should have. For me I see salvation as that which is well-being or wholeness. I see health care and the Christian faith being one in that sense.

Rev. Richardson echoed those sentiments. “Physical and mental. Of course there's the spiritual side. If physical and mental aren't up to par, you can forget the spiritual.” Rev. Thomas framed the interdependent nature of body and spirit in the spiritual heritage of his church.

Our Jewish forebearers did not see the distinction between the sacred and the secular. Likewise, they didn't see the distinction between spiritual and physical. It was all whole. Our African forebearers had a more holistic approach to who we were as peoples. That's more of a Greek concept, this kind of dualism, this kind of dichotomy. That's our focus... We have a holistic Christ and we need to be a holistic people and deal with ministry in a holistic way.

The spiritual heritage that Rev. Thomas references does not appear to be a universal construct across Christian traditions. Webb et al. (2011) surveyed faith leaders

about their perceptions of health and wellness. Some of their participants indicated a more dichotomous understanding of the nature of humans. Those participants expressed a separation between the spiritual and the physical dimensions of humans and viewed the mission of the church as attending to the spiritual rather than the physical needs of the congregation.

The participants all referred to the primary dimensions of body, mind and spirit. The secondary dimensions were mentioned by a number of participants and were generally grouped together. Tables 7 and 8 present the ways in which participants described the various dimensions of holistic health.

Table 7: Participants' Descriptions of the Primary Dimensions of Holistic Health

Primary Dimensions	Exemplar Statements
Physical	<p>It's beyond the absence of disease. It's ... the prevention of diseases or, and particularly for those already having a disease, being able to manage it appropriately.</p> <p>The body and mind are a part of each other, but I see the body as physical and the mind as being more of a mental issue.</p> <p>When we talk about physically again, this ties into us recognizing how we're using our body, what we're putting into our bodies, what we're using our bodies for.</p> <p>The capacity that allows us to be able to function and do those things that we need to do so that life is enjoyable and that we're able to be comfortable.</p> <p>Anything that has to do with the physical well-being of persons.</p>

Primary Dimensions	Exemplar Statements
Mental/Emotional	<p>It's also having a balance in terms of emotional, physical, etc.</p> <p>The mind itself has to have a desire to find peace. I think that's overall for everyone. I think everyone desires to have peace, peace of mind.</p> <p>To find out if somebody is emotionally healthy, I wouldn't say that they are free of any kind of challenges emotionally but at least they find out that there are some things that need to be addressed they do address them and try to get help. And I would think, you know, they would be trying to move to addressing some of those challenges they have.</p> <p>If you are spiritually or psychologically diseased, it leads to physical consequences. I know that personally. Stress can kill you. And so it is important that you deal with all of those things.</p>
Spiritual	<p>I was reading recently where there was a study about the importance of spirituality in physical healing. I believe even more so after my episode [quadruple bypass surgery], that it must go hand in hand for the two to make a complete holistic person and the recovery process.</p> <p>The sin of not taking care of your temple, your body. Yea. It's...I don't see a separation. I do not see a separation. 'Cause you're supposed to take care of yourself, your temple. If your spirit's not right your physical body and mind aren't right. So it all goes together.</p> <p>How can we best look at spirituality, can prayer, could prayer life maybe prevent things? I see that as a very important part of this role and the health care. Through the real holistic piece and looking at the body, mind and spiritual components of it. Not just drugs, not just medicine. How important are the other factors in our healing?</p>

Table 8: Participants' Descriptions of the Secondary Dimensions of Holistic Health

Secondary Dimensions	Exemplar Statements
Intellectual/ Cognitive Economic/ Financial, Social	<p>And that's why I like our SPICES acronym. It acknowledges that we need to deal with ourselves spiritually, physically, intellectually, cognitively, emotionally and socially.</p> <p>I talked about economic, I talked about emotionally, socially, physically. Again, in a holistic kind of approach to that, again, as persons we have many sides to ourselves and it takes, for someone to be healthy or whole, so to speak, not necessarily talking about being whole, we have to be attentive to all those areas.</p> <p>When I think of health I think of physical health, I think of emotional health, I think of spiritual health, I think of mental health, I think of economic health, I think of all of those things.</p> <p>Because certainly physical health can impact our financial health and I see those two as connected....Even how we use our finances. Are we using just our finances for us?</p>

Sources of the Definition of Health

The participants' definitions of holistic health appeared to spring from two primary sources—personal experiences and their Christian beliefs and doctrines as depicted in Figure 4. Their personal experiences can be divided into two categories—personal health issues and ministry program experiences.

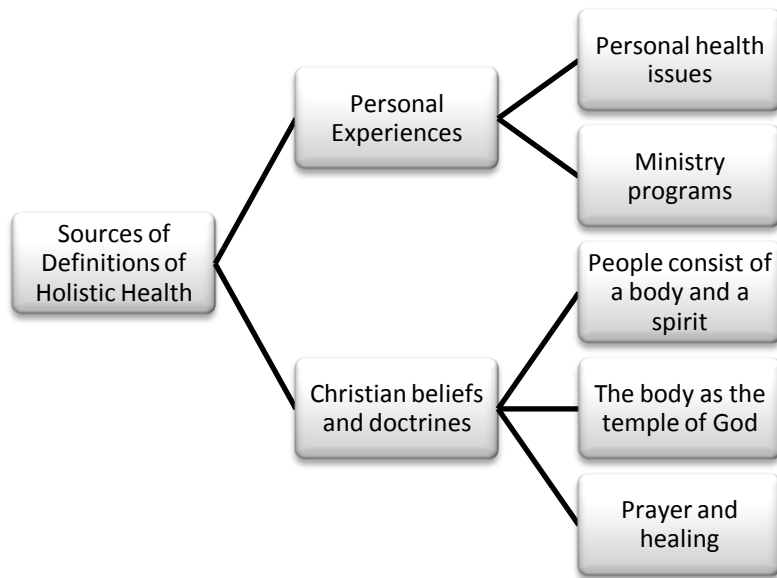


Figure 4: Sources of Definitions of Holistic Health

The participants' personal experiences included personal or family health problems such as heart disease, cancer, high blood pressure, and diabetes. For example, one participant discussed the impact of her personal health history of cardiovascular disease. "I'm a survivor of a quad bypass. I think my definition of health has changed tremendously." Her approach to promoting health among the members of her congregation and the surrounding community had a strong emphasis on prevention and screening that she linked to her personal experiences. Another participant mused regarding his family history of diabetes and his future. "My father is a diabetic; my grandfather is one, my uncles. It has not hit me yet. The doctor said it will one day but it he doesn't know to what effect."

Participants had developed their perceptions of how health might be defined through previous experiences in health ministries. Two participants spoke of a denominational program with which they are involved. It is a health promotion program targeting adults, SPICES for Life. The SPICES program acronym reflects a holistic approach to health.

SPICES reflects a holistic or whole-person approach to improving health in the African American community: just as the right combination of spices adds flavor to foods. The goal is for people to take charge of all aspects of their lives, including spiritual, physical, intellectual, cognitive, emotional and social health.

SPICES stands for:

Spiritual: being aware of how our spirit affects our health

Physical: taking care of our bodies with exercise and good nutrition

Intellectual: making decisions that lead to healthier lifestyles

Cognitive: setting goals to maintain a healthy lifestyle

Emotional: using techniques to reduce stress

Social: developing social skills that foster support systems (*Virginia Program for Healthy African Americans, Blacks - AARP bulletin*).

One participant's definition of health was directly related to the SPICES acronym and he referred to the dimensions of health represented by SPICES on a frequent basis throughout the interview. Another participant reflected upon the issues he had observed during his pastoral and counseling duties. He placed a strong emphasis on the impact of economic or financial health on physical and spiritual health. "...with this bad economy people being mentally strained and stressed affects their physical being. For me it's the whole piece when I think of health." The other individual who works with the SPICES program repeatedly referred to her experiences with the program as a factor that shaped her perceptions of health. Another individual spoke of the importance of health messages

and how these messages have become integrated into the ministries of the church.

“Health care agendas and issues have become important to the point that now I want them to be woven into all of our overall Christian education curriculum for our youth as well as for our young adults, as well as for our middle age and seniors.” Rev. Thomas, when asked about his definition of health, spoke extensively of physical health in the context of an on-site clinic the church incorporated into their ministries and the partnerships the church has with various health providers throughout the city. Likewise, when speaking of psychological and spiritual health, both Rev. Thomas and Dr. Pierce framed the discussion in terms of their counseling ministry and how the church refers people to professional counseling when necessary.

The information contained on church websites corroborates the perception that holistic health is integrated into the fabric of church ministries. For example, one church’s men’s ministry had the following mission statement on its website; “to support all men physically, emotionally and spiritually at [this] Church and the community at large.” The same church describes the activities of its daycare as “... adequately prepared to help develop your child culturally, educationally, physically, socially, and spiritually. The [church] Facility has on its grounds a fenced-in playground and a gymnasium.” The denominational organization’s website has information regarding SPICES for Life, partnerships with non-profit health agencies such as the American Cancer Society, assistance with disaster preparedness, social justice and meeting human needs.

Christian doctrines and beliefs appear to be foundational to the ways in which the clergy members define health. One participant expressed an understanding of health that was nearly inseparable from his faith. “For me I see salvation as that which is well-being or wholeness. I see health care and the Christian faith being one in that sense.” Three primary belief themes emerged from the data. They were (a) people consist of a body and a spirit, (b) the body as the temple of God, and (c) prayer and healing.

The belief that people consist of both a body and a spirit appears to be foundational to a holistic view of health as physical, mental and spiritual. One participant stated it succinctly, “you've never seen a disembodied spirit because the spirit and the body are related.” Rev. Thomas referred to the body and spirit as “inseparable” in his understanding of the Bible. Rev. Burton encapsulated the body and spirit connection. “We in the faith community, especially in Christianity, speak of the spiritual, the physical. We see Christ as being all God and yet all human—the spirituality and the flesh coming together. So if we can think of that in a concept of what we believe, then certainly we see the importance of having the body and the spirituality coming together.”

Four participants spoke of the physical body as the temple of the Holy Spirit. Rev. Thomas suggested that the concept of the body as the temple of God is foundational to a Christian understanding of health. “Your body is the temple of the Lord is the classic Biblical basis for our understanding that we, as...physical, psychological and spiritual beings are responsible for the gift that God has placed in us.” This belief has its basis in I Corinthians 6:19-20 that says, “Do you not know that your bodies are temples

of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore honor God with your bodies.” For example, Dr. Walters said, “As a matter of fact we can get Scripture to talk about the body as considered a temple of the Lord's. And that means for us to be taking care of that temple and to make sure that we are able to carry out the plan that God has for our lives.” He went on to say, “You can look at me and say ‘that cat is sinning all the time’. But... it depends on how you define sin. From a biblical, theological standpoint it [sin] is missing the mark. If we are missing the mark as far as health is concerned and God has a different plan us, that's sin. If we are missing the mark in any way, in the use of our money, in the use of our bodies, that's missing the mark as far as God is concerned.” Rev. Richardson framed “taking care of your temple, your body” as part of being holistically healthy. “Cause you're supposed to take care of yourself, your temple. If your spirit's not right your physical body and mind aren't right.”

Prayer and healing were linked to health via the spirit, mind, and body connection. Rev. Roberts repeatedly emphasized the importance of prayer in maintaining health. For example, he described his beliefs regarding the connection between prayer and the physical body.

I think prayer plays a major part in our attitude about health. If, because... medication and therapy can only work as long as our minds are positive... the more upbeat we can be, the more positive our minds can be, the better, the less stress we have... I have this feeling too about prayer raises our vibrational levels in our bodies. Our cells vibrate. I think prayer helps our cells to vibrate properly. So I think the two would have to kind of go together.

Dr. Pierce participated in a study of the effects of prayer on stress level as measured by blood pressure levels. She expressed that

prayer does allow you to be able to deal with the everyday problems of life. Knowing that you are in communication with God. Knowing that you have an avenue to talk with God. Knowing that God is available and accessible to you. That allows you to be able to endure... Healing is believing, you know, that we are capable of being healed regardless of what the disease is. And that healing can happen on this side or it can happen beyond this life. But that the God that we serve is available to heal. And that healing begins mentally. It's mental as well as physical. That ...we have responsibility in our own healing.

Rev. Lewis suggested that he would like to see research on prayer and fasting to explore the connection between prayer and fasting and health. "I would be interested in research that would like how does prayer impact stress. Is there a relationship correlation between an active prayer life and the level of stress that people deal with...What impact would fasting have on our ability to control or manage our diet?... As you see it's based out of those fundamental spiritual principles and how those established spiritual principles lend to wholeness, balance."

Participants did not see traditional medicine as outside the bounds of their beliefs. In fact, they saw it as integral to the process of being healthy. One participant expressed that "healing is not just relegated outside of medicine. And so we believe that doctors are agents of our healing. Medicine can be an agent for our healing. Altered lifestyle, changing our way of doing things, our ways of eating, and all of these things, ultimately God is in control. But God may use a doctor, God may use a diet, God may use medicine. And so those are part of the beliefs here. So we don't deny the ability or the power of God to use doctors, nurses, caregivers." Participants' willingness to participate in health

research also suggests their acceptance of traditional medicine as a valid means of maintaining health.

Characteristics of Holistic Health

In addition to specifying the various dimensions of holistic health, the participants suggested several characteristics of holistic health. These characteristics were (a) living a balanced life, (b) health across the lifespan, (c) and the influence of systems on holistic health, particularly community and family. The three characteristics of holistic health create a framework for obtaining and maintaining holistic health.

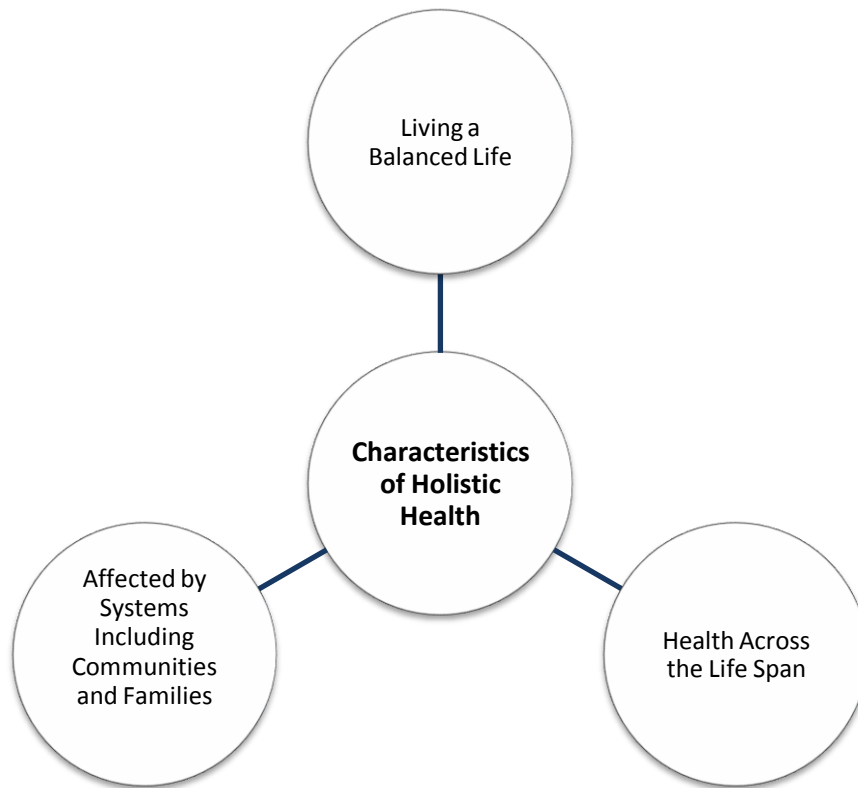


Figure 5: Characteristics of Holistic Health

First, the concept of balance and a balanced life seemed to undergird the participants' views of health. Balance and a balanced life appear to be linked to the interdependence of the various dimensions of health. The influence of one dimension of health on another was a consistent thread running through the findings. "It's also having a balance in terms of emotional, physical, etc. such that one enhances the possibility for physical and emotional health." Rev. Richardson expressed the concept of balance in this way. "Try to be three parts whole—spiritual, mental and physical—'Cause it all affects, if something's out of whack, it affects the other two. And so, we do our best to stress all three." Dr. Walters referred to balance specifically in the context of his Christian beliefs. "But I guess to make a long story short I think from a Christian milieu, or Christian viewpoint, I would define wholeness as, you know, am I in the will of God or am I moving toward the will of God in my emotions, in the area of my mental health, in the area of my finances, my body, my social interactions?" Balance was foundational to Rev. Lewis' definition of health. "My personal belief is that it's a matter of balance. Everything has a specific balance. And I feel that complete health is when all of those components are in balance." Rev. Edmunds also emphasized balance in his definition of health. "Health is not merely the absence of disease, but it is also having a balanced life."

The concept of health across the lifespan was mentioned by several participants as an important element of a holistic approach to health. Health across the lifespan was presented in several contexts. The first was the influence of one generation on others. One participant described the curriculum for a summer camp the church is holding for

youth. Health education is a component of the camp curriculum. She emphasized the importance of presenting health messages to the youth as a means of reaching other family members. “So we want to make sure that we touch on those bases so that they can tell auntie and grandma, aunt and mom and dad.” A pastor from an urban church described his top priority health issue as working with children in a school setting in order to influence the health of the children and their families. Rev. Douglas spoke of the potential for health promotion research to influence the health of future generations. “We're breaking down barriers for generations to come. Ideally, so that ... my granddaughters or my great-great granddaughters get my age, they don't have to worry about having high blood pressure.” Health across the lifespan was framed in terms of the long term impact of illness and disease on lifetime health. “Because of the obesity epidemic, and you know, we know it particularly impacts everybody, particularly your African-Americans and Hispanics...but that's where we're seeing morbid obesity even in children. So, so you're seeing Type 2 diabetes, starting at nine and 10 years old. It's sad. So we added in as adolescent component to our SPICES wellness ministry.”

The findings suggest that community, family and individuals were viewed as interdependent and that the interdependence of community, family and individuals affects health. These interdependent relationships were discussed by several participants. However, one participant spoke of a systems approach that framed his thoughts about the influence of community and family on health. He views communities as organisms with multiple interconnected systems. All of the systems affect health. He likened a

community approach to health to the human body with many systems that are interconnected. “I have to look at the church, our families, look at our community. It's not just organizations but an organism. There are various systems that interact to make that body healthy or not. That's in the family, that's in the church... So all of it's connected.”

The most prominent systems mentioned by participants were families and communities, including the faith communities themselves. Rev. Roberts spoke of the impact of family structure and caring for elders as an issue affecting health, particularly mental health, which needs attention. “...senior citizens' care. Because this is an older church and a lot of people have had to care for some of their relatives. And that's become a kind of problem. And that too becomes a part of that self-esteem piece. How do you keep someone upbeat when they are going through so much caring for a loved one?” Other participants mentioned family as key influencers of health behaviors. For example, Rev. Burton described the important role family would play in a study she envisioned on cardiovascular disease education. “And in educating the family on how to care for them then I'm educating them on how to care for themselves and the others that are behind.” Rev. Douglas discussed the intergenerational influence on health of breastfeeding and maternal nutrition. “It's [breastfeeding is] much healthier for the mother and good for the daughter...I don't know if enough research has been done on having a breast fed baby, when they starting to get older, some of these chronic illnesses. Where do they really come from?”

The church's responsibility to address community health issues was raised by several participants. For example, Rev. Burton described the responsibility she feels for educating the community about health issues. "This is an opportunity for health awareness to be promoted. Coming from the faith base because all the time people are not comfortable of hearing information--they're so accustomed to hearing information coming from one source and that's the health community. Now when you have it coming from a different venue, will their ears perk? Ahh. But you've got to have the voice. The church itself has to feed in to it." Other participants expressed similar sentiments about their communities. "I just feel that there are so many needs and so much pain out in the community that we, for me, some kind of way to make sure that we keep our hand on situations." Rev. Richardson's church is actively involved in addressing health needs in the community through a feeding program. "In the community, every third Friday we send food to 30 families and you do not have to be a member for us to give you the food... We deliver, the church pays for it." In describing his ideal research project, one participant focused on working with the city schools to enhance health by working with children. "But because we're in the city, if there's money available we want to get it to the right people. Because even for us to hold it wouldn't make sense if we don't use it for the community." Dr. Pierce, a cancer survivor, uses her personal health issues to educate her congregation.

You know I'm a cancer survivor. And so the congregation has watched me as, you know, I had to...as we live out our health issues. So we've done that in community. So I continue to live out the fact that faith, you know, as we are constantly walking by faith. Even in the midst of our health struggles. And so

that is always good for people to be able to see that model before them. Or model among them rather. Because I'm not the only cancer survivor. But it did allow people to admit their physical struggles, their health struggles. And when I developed cancer, I chose not to wear a wig. I chose to just allow, you know, the natural look. And a lot of women have chosen to do that here.

The participants holistic definition of health emerged from two primary sources—personal experiences and their Christian beliefs and doctrines. This holistic definition of health has three characteristic—living a balanced life, health across the life span, and the influence of systems such as community and family.

Partnership Structure

The following section presents the findings related to the second research question. How do faith leaders envision a partnership between faith communities and health promotion researchers to be structured to address the most pressing health concerns facing their congregations and communities?

Approaching Faith Leaders

Participants described three methods that researchers might use to approach clergy regarding participation in a study. They had experienced researchers approaching them through a) unsolicited letters, emails or phone calls, b) other staff members or volunteers, and c) pre-existing relationships with varying levels of effectiveness.

Participants' experiences suggest that unsolicited letters, emails or phone calls can work but often have limited impact. In one case, a phone call sparked a partnership. "The project was described as a necessity for research and yet the importance of the faith community being an active participant, I think it was in her presentation, that she shared the importance of the research, the long term effects that the research would have on health issues. And that's what sold me."

However, two participants did not remember receiving an email or follow up voice mail from a breast cancer message research team. "No, and I could have. I get a lot of emails and I could have been contacted." Dr. Walters indicated that he would have been willing to participate if he had realized he had been contacted. A similar failed attempt to make contact with a congregation included a personal introduction. In this case, the breast cancer message research team sent a letter of introduction via a person who was familiar with the clergy member. She dropped off the letter and the team followed up with a voice mail. Once again, the pastor did not remember being contacted and expressed that he would have been open to participating had he been aware. Emails, letters of introduction, and phone calls seem to have been an ineffective method of making contact with pastors.

Small or rural churches were described as particularly difficult to contact directly. A denominational official described his experiences in working with rural congregations in his denomination. "But the rural congregations where just have somebody in the office a few hours of the day on Wednesday, Saturday, and Sunday. Some not even on

Saturday so much. So that's the other challenge of working with rural congregations is that you can't just make a phone call and get somebody in.” The lack of staff with which to make contact appears to add an additional challenge to contacting small or rural congregations.

Another method of approaching pastors and their congregations is via other staff, volunteer leaders, or organizations. A denominational official described how one research study team began approaching churches directly and then realized “there's a network of people who do health ministry. How much time should we spend trying to contact churches when somebody can tell me who I should go to?” Then they approached a denominational official to gain access to congregations via the denominational health ministry. The denominational official described how he approaches churches within his denomination to consider participating in research. “What works for me is pre-existing relationships. What works for me is if they are a participating church in the [denomination]. They at least feel some obligation to at least return a call.” In this case, the denominational official functioned as a bridge between the research team and the congregations.

Other leaders within a congregation can be valuable in bringing health research to the pastor's attention. “So at the same time as your reaching out to pastors you also have to reach out to other leaders of the church... because sometimes that person can get the pastor's ear.” The leaders of health ministries were suggested by two pastors as natural entry points to their churches. The health ministries of the churches in this study are

typical of health ministries or parish nursing ministries in churches (Giger, Appel, Davidhizar, & Davis, 2008; Holt et al., 2009). These ministries, generally run by parishioners who are RNs, provide health education, screening services, and individual assistance to congregants. “They’ll call the secretary and because the nurses do things year round and because of the breast cancer group. The chairpersons [the nurses who manage the health ministry] talk to those people. And they take it from there. Of course, they let us [the co-pastors] know.” Rev. Thomas indicated that he would not want to be directly approached, preferring to have researchers present their proposal to the health ministry first. “They [the researchers] would have to provide us information in terms of what they wanted from us. And then what they expected to accomplish. Then I would meet with Rev. Martin who is over our health care ministry...to find out 1) if it would be beneficial, advantageous to the community and 2) whether we could actually help get done what needed to get done.” Rev. Lewis described the connection that some of his parishioners have with the local university and how that led to his being approached by a researcher. “I think probably through several of my parishioners who are, they are connected with [the university] either by employment or they were retired [from the university]...They operate either as parish nurses, as RNs, various specialties. When they heard of this occurring in the community, knowing that the pastor is community minded there must have been some conversation. And I received a call.” Connections that researchers have with faith community members, particularly those involved with health ministries, appear to be a viable method of establishing contact with pastors.

Pre-existing relationships appear to be a useful mechanism for establishing research partnerships with faith communities. “In this particular case, people [investigators] got to know us because of SPICES. It gave us a lot of exposure.” These relationships may be fostered through providing services or education to faith communities. “...a lot of times [the university connection] would be the extension service that we would go to provide seminars related to health and nutrition.” Rev. Douglas spoke repeatedly of the importance of establishing relationships, particularly to members of the African American community. “We’re relational people. You talk about trust, build a relationship. We just want to come and give you some products. For some reason, I don’t know what it is about us but I can give you a gadget, just one that could have [university]-something with [the name of the university] on it...Some things--water bottles. Drink more water. Every time I drink water I see. Little things like that.” Small gestures or a casual acquaintance may be sufficient to warrant responding to a request to participate in a study. For example, Dr. Pierce described her prior relationship with an investigator. “I knew her vaguely. I’m trying to think of what circles we knew each other from. But you know, it’s movement in community. Yes, I knew her before the study, or had heard of her. Because we have members of [the church] that are in nursing school and so I knew of her. And I knew I had seen her once we met. There were some things [community activities] we may have worked on.” One participant who is a former city official and well known in his community described his personal relationship with top university officials and how that has led to contacts from researchers. “I could go to any

game I wanted to. [laughter]. I mean I sit in the president's box. I had access. People knew that they were very fond of me. Also, one of the former rectors--as a matter of fact they used to call me junior rector because I was so close to the rector. And I called up there and I could get things done. I still can...Sometimes it's the doctors. They'll look me up, especially if it has to do with minorities, African Americans specifically.” This individual has a unique relationship with the university that would not often be found among clergy members but it suggests the potential for using pre-existing relationships to establish connections for research.

A Well-Organized Study

Several participants expressed an appreciation for and expectation of a well-organized study. They view their time as important and researchers who come with a coherent, organized proposal are more likely to be viewed favorably. Rev. Douglas described the interaction with the investigator. “She was very helpful in helping me to get my job done so that I could help her.” Rev. Burton expressed appreciation for how well organized the researchers with whom she worked were. “The project itself was well organized. Everything was explained in detail. Any questions that I had were answered before I even asked them. It was as if [the investigator and her assistant] knew what we were looking for... You see, in a faithbased community, especially here at [the church], we are such an active church and there's so many things going on and you have but so many workers in your church so it's important that you have, if you're going to do a research study, that the material is there, ready to roll and all you have to do is put the

people in place.” Rev. Allen referred to a health promotion project on which he worked and how it was organized. “And they know the specifics like. ‘Go to the radio station. You’ll be interviewed, then Dr. [a physician]...I’ll take care of it.’ I don’t want to sit down and do the thinking through it.” He was willing to do whatever is necessary as long as he does not have to do the actual planning or attend any meetings.

Meaningful Outcomes

Participants consistently spoke of the importance of research that addresses health issues affecting the congregation and community. As they evaluate whether or not to enter a partnership, the clergy members who were interviewed expressed that the study had to have outcomes that benefited their congregations and their communities after the conclusion of the study. One participant expressed it as a question he would ask, “What comes after, what are people left with?” Each participant spoke of outcomes and the importance of practical application of the results, either in the short term or over time. For example, Rev. Richardson focused on practical application of the results of research. “What is the latest that can help my mother, my grandmother who’s going through whatever issue it is?” One participant framed his comments about outcomes in terms of the fears and discomfort that congregants experience when asked to participate in health research. He felt that tangible results would mitigate the discomfort. “I think if we’re going to ease people’s discomfort with being involved in any kind of research we have to show that the result of that leads to better health outcomes.” Rev. Lewis spoke often of the importance of tangible benefits. “I would bring my people in place to see how we can

identify something that will provide tangible benefit, tangible, measurable hopefully, of course.” Rev. Allen wanted to participate in research that resulted in “sustaining life, improved quality of life, helping you become whole, and correcting any problems.” The findings suggest that meaningful, tangible outcomes should be clearly presented in the initial stages of approaching clergy members and their congregations about research participation.

Relationship with Investigators

Participants expressed a desire to work with investigators who are willing to work with the community in meaningful partnerships. These meaningful partnerships include (a) collaboration, (b) researchers investing time with the community, and (c) respect for community members.

Collaboration involves working together to accomplish the goals of the study. However, collaboration in this context appears to involve flexibility in terms of roles, responsibilities, and activities depending upon the circumstances of the study. Dr. Pierce expressed her desire to see collaboration from the beginning of a study. “Well, I think that most people want to see that, the community wants to see that there is a buy-in from us [faith community leaders]. In other words, you can't do things *for* us or to us, but you have to do things *with* us. They need to know that there's somebody that is with them that has their like [similar] experiences and looks like them, has been at the table even if they couldn't be there.” Clergy members may serve as the persons who have had the

similar experiences and can represent the parishioners' interests. She continued to outline the importance of collaboration between the faith community and the academic community. "[Research may provide an opportunity] for us to see again, the connection between first of all between us and what others are doing. That a lot of times in the church we forget that we are connected. That there is a team. And so we do pieces. [The university] does a piece. There are other people who are doing. We work together and learn how to have cooperative efforts and so it blesses both of us." The above quotes also illustrate the importance of collaborative relationships that have the potential to benefit the community. Rev. Lewis spoke of collaborating to determine ways in which the community could benefit from the work being conducted. "Part of their charge was to actually not only just identify the [health] disparities [experienced by the Black community], but actually to put together events, community events, to partner to community organizations that are sensitive to the various issues regarding disparities, especially within the Black community." Rev. Edmunds described the collaborative relationship he has with whom he is currently working. He focused on the interpersonal aspects of the collaboration. "The PI has been great in saying let me run this past you before I put this in there...So it was very, very much a collaborative process."

The willingness to spend time in and with the community was an important aspect of a productive relationship among researchers and faith communities. Dr. Walters framed his desire for meaningful interactions with researchers in terms of spending time with the congregation and community. "Come and be a part of the community so you

can see the dynamics. I think as a researcher you'll pick up on a lot of things... Rather than just, a personal affect helps... Rather than just sending a survey, saying 'Would you do this? Share it with your congregation.' But you get much better results if there's a face that people see with that and that person is in worship. That researcher comes and worships with them and they begin to see." Rev. Douglas framed her comments around the stigma that is sometimes attached to research, particularly by older African Americans. "So how do you get around the stigma? Just to have a presence in places like the [denomination]." The stigma of research is connected to historical mistreatment of African Americans in research such as the Tuskegee syphilis study. Hamilton et al. (2006) found similar sentiments among the older participants in their study. Time in the community has the potential to demonstrate a commitment to that community, according to Rev. Lewis. He felt that in order to establish a relationship with a community being physically present was critical, particularly in African American communities.

Commitment gets you into my neighborhood, relationship gets you into my house. One of the nonprofits that I work with did not even know, I mean, this person is executive director, multimillion dollar nonprofit that can funnel moneys to do programs, especially in low-income areas, and only to find out that all this time, that she's been in her role as executive director, asking me what could be done to further reach families in our community. Only find out she's never been to the community. She's never, never got in her car, took a drive over here to public housing and met people. You know, everything that she did was, you know, theoretical research findings, statistics, you know. But never that personal connection.

The importance of respect for community members as people was expressed in strong terms. Rev. Burton shared that she was looking for "researchers who are willing to come into the faith community. Researchers who are willing to come with an open

concept. Researchers who have actually done their homework and not looking at the faith based community as guinea pigs. But who actually respect the participants that are in front of them. We're not just there for a statistic. We're actually walking, talking human beings with issues--social and emotional.” Dr. Pierce and Rev. Roberts, both from churches in low-income, predominantly African American neighborhoods, framed the respect in terms of their communities’ previous experiences with an academic medical center affiliated with a local university and ways in which the university and academic medical center might improve their relationship with the community. They emphasize how positive interactions with individuals from the university can enhance the relationship. “Cause a lot of times [the academic medical center] is not well thought of, especially in this area. They always want us as guinea pigs. They always want this, they always want that...Now we work together. You know, we have something to share. There is something of value that they are learning from us. Or that we share common beliefs. So that's good.” Rev. Roberts spoke in broad terms about his perceptions of campus/community relations. “I just don't see it [the university] as being part of our community. There's no trust there at all, in that sense. As a matter of fact, I think that's one of the problems with universities. ...We used to have presidents speak out on issues. Talk about certain things. You, very seldom, do you see any of that now...I don't feel they speak out like they should about some of the injustices...I don't feel there's any relationship.” However, he went on to discuss more positive interactions with the university’s school of social work. “I've seen some of the social workers, I think,

involved in a program here that we have on voter restoration rights, prison reform. And that sort of thing is just good for the university...that makes it very positive.” Rev. Lewis served on a steering committee designed to make recommendations to redress historical wrongs that began with slavery. He pounded the table as he spoke of his interaction with the university on racial reconciliation and his perceptions of the history of the relationship between the academic institution and the African American community.

So when an outside agent or entity or external entity comes in wanting to provide what they feel is a service, I think there is an insensitivity in recognizing that what you're feeling is a service is beneficial to us [the African American community]. Well, our response is, we've had in the past people coming as sheep when they turned out to be wolves. They handed a gift to us and found out that the gift ended up being a nightmare for us. We have a history of that...There's going to have to be an effort, a demonstration, ...where everybody can connect with it. There's gonna have to be a resource transfer. You know, whether it be financial, you know, land, there has to be some type of very large, substantial, tangible, giving back.

While the above comments refer to institutional concerns beyond research, they may have implications for individual researchers as researchers represent the institutions that may be viewed with suspicion and distrust.

Roles, Benefits, and Barriers to Participation in Research

This section addresses the third research question. What do faith leaders perceive as their role in health promotion research? What are the benefits of assuming this role? What are the barriers to assuming this role? How could they more effectively perform this role?

Overview of Roles

The clergy members interviewed for the study identified several roles they could envision themselves assuming. They also indicated a desire for varying levels of involvement in research from only approving the study to involvement in the design of a study. The clergy members had assumed or envisioned themselves assuming several roles in a health promotion research study. The roles are (a) provide approval, (b) recruit participants, (c) identify volunteers, (d) lend influence, (e) keep information flowing, (f) serving as spiritual teacher/educator, and (g) provide input on the study design.

Preferred Levels of Involvement

Each participant expressed a preference for a different level of involvement. Two participants, both pastors of a large, urban church, indicated a preference for limited involvement. They saw themselves as the persons with the authority to authorize conducting a study in their churches but did not want any further involvement. They indicated that volunteers were better suited to handle the administration related to conducting research in the church. One expressed a sentiment that was echoed by the other. “We [the co-pastors] trust the chairpersons of the nurses’ ministry and the other health ministries. That’s something we don't need to be involved in. As long as they let us know what they would like to take place and we approve it. It's just something to add to our plate.” Most of the senior pastors preferred leaving the administrative details of working with researchers to others in the church. All participants described themselves

as “busy” but the responses suggested that senior pastors have the most significant time pressures. “I think with most people when they think about reaching the church they tend to almost always target the pastors who are the busiest persons there, [who can be] pulled off track in a moment’s notice.”

Most participants expressed a desire to assume additional roles although the type of role and extent of involvement varied among participants. For example, one Christian Education Director expressed a desire to have more hands-on involvement in a study as a “conduit of information” and in recruiting participants. She felt it was her duty to provide health information to her congregants, both during and after conclusion of the study. The senior pastors also included various combinations of the other roles.

However, none wanted to become intimately involved in the research. One expressed a common sentiment that he would like to be “somewhat involved so I can understand the aims of the research and how I might even use my influence to get the end result. I don’t necessarily have to see every question and everything and screen it. But I would want to know... the gist of what is this research, how is it going to benefit us.” Rev. Roberts expressed a similar desire to have a basic understanding of how the research would be conducted and have input on one specific aspect of the study—participant recruitment. “I’d like for them to put it together and I’d like to be able to look at it and review it and to have input...I’d like to kind of being part of making sure it has a view from all segments of society.”

One denominational official expressed the greatest desire to be involved in the research. He indicated that he might consider serving as a co-investigator on a study. This individual has research experience as a co-investigator on several studies. No other participants indicated an interest in being involved at this level.

The participants were queried regarding the relative priority of participating in research. Research was generally viewed as important. However, regular responsibilities of the pastorate need to be balanced with participation in research. One participant expressed it as, “That would have to be a lower priority. I couldn't put it up in from of the immediate needs of the congregation. It would be something that would be a lower priority because I could not give it 100 percent.” Another expressed great enthusiasm for research but indicated that her job responsibilities left little time for involvement in research. “To be honest with you, it is at the bottom...Because my job is to minister, to teach, to preach, to plan classes...That is not a part of my everyday thinking. It's [participating in research] not a priority for me.” However, others indicated that participating in research might be a higher priority if the study met certain criteria. Rev. Allen emphasized setting an example as a motivating factor for participating in research. “It would become important especially if it is providing leadership for my church. If it is setting an example, it is a very high priority.” Reverends Roberts and Lewis expressed that participating in research might be a higher priority for them, if the research explored a topic in which spirituality was a component of the research. “[Research is] near the top [of my priorities]. Not quite, but near the top anyway...because I think when you say

health research I think it's important for us to look at how spirituality can help with healing...the part the mind plays with our healing. .. How can we best look at can spirituality, can prayer, could prayer life maybe prevent things?"

My commitment... had its parameters. And they were somewhat limited because my plate is full...I really would have to look at the type of research and ...how I would be able to draw a benefit which would be directly related to what I do being a faith, spiritual, faith leader. Because for me, of course, spirituality is the genesis by which everything else... It comes from the soul...So I would need to find benefit in whatever the research is that would help enrich, broaden, and provide a greater understanding of what I do as a spiritual leader. I think that and only that would provide a level of interest for me.

Two other senior pastors used the phrase "my plate is full". It seems to be a common theme, particularly among senior pastors. It suggests that their busy schedules require that they evaluate the relative benefits of every activity in which they participate.

Role Descriptions

Clergy members described seven roles they might assume in research. They are summarized in Table 9.

Table 9: Clergy Roles

Role	Definition
Provide Approval	Clergy member is the person with the authority to authorize or reject a request for participation in a study.
Recruit Participants	Clergy member actively recruits participants for a study.
Identify Volunteers	Clergy member identifies volunteers to assist with the study.
Lend Influence	Clergy member is a trusted advisor and exerts influence on the

	congregations. Clergy member serves as a bridge between the researcher and congregants. This role may include introducing the study to the congregation and encouraging participation.
Keep Information Flowing	Clergy member functions as a conduit of information from researchers to congregation and back to the researchers both during and after completion of the study.
Serve as Spiritual Teacher/Educator	Clergy member provides the teaching on spiritual messages related to the study issue or topic (i.e. cardiovascular disease, weight management). He or she may educate congregants on the importance of the health issues to their lives. The clergy member may create the spiritual content or review and approve spiritual messages created by the investigator.
Provide Input on the Study Design	Clergy member participates in the design of the study either in an advisory capacity or as an official investigator.

Provide Approval.

The data suggest that a highly centralized approach to approving research proposals is the preferred method. The participants saw the senior pastor as the final authority on making decisions regarding participation at the congregational level. While some pastors indicated that they would consult with others within their congregation, the final decision to participate in a study rested with the pastor. Several participants spoke of the authority of the pastor to make decisions in the African American church. For example, Rev. Allen said, “If I say we’re gonna do it, we’re gonna do it. It’s not up for discussion.” Rev. Edmunds as a denominational official saw himself in a decision-making capacity for denominational involvement in research. However, he recognized that the pastor would make decisions for each individual congregation.

However, the participants held varying views on how studies should be administered and by whom. All participants recognized a need to delegate some tasks but the amount and type of work delegated varied as did the persons to whom the work would be delegated. “I know that... we get more done when the pastor knows about it and says, ‘yes’, but has somebody else to do it” is an exemplar statement of centralized control held by the pastor and delegating the organizational or administrative tasks to others.

Recruit participants.

Pastors saw themselves as assisting with recruiting participants for the study, primarily because of their knowledge of the individuals within their congregations. For example, one pastor envisioned himself in that role because “I kind of know the conditions people have.” Another described her knowledge of the congregation and community. “My role is having hands on access to the participants. Now the research can only go but so far because there's not an interpersonal relationships that has not been established as of yet.” Rev. Edmunds also addressed the concept of established relationships and the necessity of having those relationships in order to recruit participants. “They're not going to do it by just saying come do this survey or come participate. It has to be nurtured to develop an understanding of the whole process. It takes some time.” For him, the time commitment required to develop the relationships necessary for recruiting participants was burdensome and a potential deterrent to

partnering with health researchers. However, for clergy members who work in ministry with one congregation, relationships already exist, therefore mitigating this concern.

Identify volunteers.

The rationale for assuming the role of identifying potential volunteers was similar to the rationale for assisting with participant recruitment. Several participants indicated that they consider themselves to be knowledgeable about the members of the congregation and the members' existing interests. "And I think I know quite a bit about who I think we could call." Several participants suggested that they would recruit volunteers who were already involved in health ministries to assist with a study. Existing health ministries or parish nurses were most often mentioned as a source of volunteers. Rev. Edmunds spoke of his experiences with finding volunteers for the research study in which he is involved. "...they're volunteers. We do it because they already have the health ministries." For example, the health ministry in Rev. Richardson's church would serve as the portal of entry into the church and coordinate with the researcher after the study has been approved. "The nurses do thing year round. The chairpersons talk to those people [prospective researchers]. "And they take it from there." Rev. Thomas relies on the nurses in the health ministry from his congregation as well. "But I know the way I would work that is through our health ministry." In the case of the study at Dr. Pierce's church, the volunteers were not health professionals but received training to fulfill their roles. "And so we had what we call health—I forget what they were called—and they were able to take the [blood] pressures." The findings suggest that both health

professionals and lay health volunteers may be enlisted to conduct administrative and organizational tasks related to research.

Lend Influence.

Using their influence to bolster participation in research was the second most often mentioned role clergy members envisioned themselves assuming. They viewed their leadership position as one of influence that could be leveraged to encourage successful participation. Speaking about research from the pulpit was seen as a way in which they could influence their congregations. Dr. Walters spoke of “lending my influence, because certainly in our tradition...pastors are many times are trusted people and usually if pastor tries to tell them, make sure he or she is informed and shares information like that.” Another spoke of using her knowledge of her congregants to introduce the research to the church. “Just like the study was here, [the investigator] trusted me to present it to the congregation because, you know, people in the communities... how they receive has to do...with who presents it. It doesn't mean that it's not good information but it can die before it ever gets a chance to live.” Dr. Walters addressed the potential difficulties research might encounter without pastoral support. “The only barrier I can see is, you know, is a pastor not lending their influence. A pastor can say something about a project ... and give the signal that we should participate. Or they can say nothing and it dies out... If you can get the pastor on board, and he sees it as positive, and he can share it and pave the way for that congregation.” Rev. Roberts spoke of the culture of the African American church vis-a-vis pastoral leadership and the way in

which pastors are influential. “Much of, especially in the African American church anyway, much of what the pastor does, the people will follow.”

Keep information flowing.

Several participants indicated a desire to serve as conduits of information both during and after completion of a study. This information flow was bidirectional. For example, Rev. Lewis spoke of communication from the congregation to the researchers. He sees himself as a “kind of an agent/spokesman for the people I represent”. In order to facilitate communication from the researchers to the congregation, several pastors indicated that they need to understand the context and content of the study. Rev. Roberts expressed a desire to be apprised of the purpose and results of the study so that he could convey that information to his congregation. “Sometimes when we do things, we don't know exactly, we don't have all of the information or understand all of the information. So for me, I think to make sure... I would understand what's this study about, you know, why this study, what's gonna be done after the study, and that sort of thing.” Rev. Burton expressed that she felt a responsibility to convey health information gleaned from the study to the participants. “But the people themselves once the research is over are still left there. And so it's so important that my role is to keep that information flowing and going.” She also felt that it would be her responsibility to keep abreast of developments related to the area of research and convey that information to the congregation. “We know there is research ongoing... Now the responsibility that I would have would be to find out if there is any additional research or if there is a result to the research. What's the

end of that? After your research is over, then what do we do? Are there any more avenues we can explore?”

Pastors, particularly senior pastors, who would prefer a limited level of involvement indicated a preference for delegating the management of information to others within the church. For example, Rev. Thomas would delegate communication to the director of the health ministries. “We've got a number of nurses, I heavily rely on them.”

Serve as spiritual teacher/educator.

Clergy members indicated that they felt uniquely qualified to create messages that linked the study topic to spiritual or biblical content. Dr. Walters felt that being an educator was the most important role he could assume in a health promotion research partnership. “So I think pastors' role and chief role is to be educator and gatekeeper.” Another said he “would like to be involved in creating that piece [spiritual content]”. Rev. Burton indicated that spiritual messages should match the beliefs of the congregation. “They [the messages that were the content of the study] were strictly screening because, I personally feel that everyone is not...everyone does not have the same concept of religion.” Dr. Pierce was open to having a researcher propose spiritual content but she would retain final approval. “They could propose. But I would just have to see where it's consistent with our basic theological themes. And I wouldn't mind a researcher proposing. But ultimately, I would take and adapt it to our context.” She was very clear about retaining control of any spiritual or biblical messages presented at her

church. In general, the participants in the study expressed the sentiment that preparing spiritual teachings for their churches is their primary responsibility, one which they would not delegate to others.

Provide input on the study design.

Several participants indicated that they would like to have limited input into the design of studies conducted in their churches. There was a general recognition of and deference to the expertise brought to the partnership by the university investigators. Rev. Roberts indicated that he would “like to be able to look at, I'd like for them to put it together and I'd like to be able to look at it and review it and to have input. 'Cause they [the investigators] would be better equipped to design it.” He had one specific element of the design into which he would like to have input. He wanted to “look at what kind of people... would be a part of the study. Would they be from all classes, all races, all nationalities? I'd like to kind of being part of making sure it has a view from all segments of society.” One participant with previous research experience expanded the potential level of involvement to “a co-investigator and not necessarily even that. If I had to be in there something like that. Yes, if that would allow me to have some input into the design... just enough to feel comfortable that certain things have been considered. I don't want total responsibility.”

However, several participants indicated that they did not want any involvement in the study design. These pastors were the individuals who indicated that they had a heavy work load and would not have time to be involved with the design of a study.

Benefits

The participants saw two primary categories of benefits to participating in health promotion research. The first category of benefits was improved health, either for the individual participant or for people in general. The second category of benefits involved enhanced relationships among faith communities and the university.

Improved health.

The participants suggested that an important benefit of participating in health research was demonstrable, tangible outcomes that benefit people's health. Demonstrable, tangible outcomes were seen as a critical component of any research study. The participants suggested that it is important that the potential outcomes of the study are framed so that parishioners can know they have an opportunity to make a valuable contribution to humankind through their participation in research. He felt that portraying the contribution made by participating in research "is not hard. There are so many things you can point to. You know, that vaccine, this is how we got to it." He expressed the need for educating people on the benefits of participating in research. "People don't know what like they don't know how that [the development of new vaccines] happened. They think it dropped out of the sky." These outcomes were portrayed as either providing a direct benefit to participants or to the broader community as part of the ongoing advancement of medical science. Rev. Roberts spoke of the benefit to his community. "The information, it's going to give back to us is going to help us in the long run." Rev. Douglas expressed her hopes for impactful research as "to see

people healthier, living longer. So maybe even knock out diabetes... If it's [a genetic predisposition to disease] in your genes you are gonna get it. But what about things that you don't have to get? I would love to see all of that knocked out. A cure for cancer would be awesome.”

Participants indicated that it was important for researchers to report back results at the conclusion of the study and its broader impact. For example, Rev. Burton wanted to know “to what extent, to what affect, was the ripple in the water. Where did this information go and how was it used?” She felt that participating in research was like dropping a pebble in the water and seeing how the ripples spread and equated her church’s participation in a breast cancer study to dropping the pebble into the water. She envisioned their contribution to research benefiting people far beyond her immediate community.

Enhanced relationships with the university.

Several participants suggested that a benefit of participating in research was enhancing the relationship among faith community members and university researchers. This enhanced relationship includes (a) an appreciation for the work of researchers, (b) a stronger sense of community and teamwork, (c) accomplishing more together than either could do separately, (d) leveraging resources for the good of the community, and (e) establishing ongoing relationships.

Dr. Pierce spoke of creating “a greater appreciation for the work of researchers. Sometimes you know, we don't realize this is important work.” She emphasized the importance of working together to establish “a greater connection with the work of others. That we see ourselves as collaborating and cooperating with others in bringing about a greater good for persons individually and collectively...or us to see again, the connection between first of all between us and what others are doing. That a lot of times in the church we forget that we are connected. That there is a team. And so we do pieces; [the university] does a piece. There are other people who are doing. We work together and learn how to have cooperative efforts and so it blesses both of us.” Rev. Burton expressed similar sentiments when she reflected on her experiences with a university research team. “I think it afforded us an opportunity to see health care and faith base coming together. Interlock, interaction togetherness, a unit coming together as one for the benefit of everyone.” This appreciation of the potential benefits of cooperation was framed by Rev. Lewis in his comments on the benefits of networking to leverage the assets that each party brings to the table. “I think it was probably just a true network. The connection, of course, was the mission element of our particular congregation due largely to my experience in humanitarian work... And so always seeking opportunities to network and provide win-wins for everyone involved. It was how the outreach was extended to them and vice versa.” He emphasized that both parties in faith community/university partnerships bring valuable assets to the relationship with an emphasis forging relationships that provide a “win-win”. Rev. Burton framed the

relationship in the biblical story of the Good Samaritan with the researcher as the Good Samaritan and the faith community as the recipient of assistance.

And the importance of the research presented a Good Samaritan concept--helping your neighbor, you see, when your neighbor is down, your neighbor is sick, your neighbor needs something. That Good Samaritan approach. Research comes into the faith community as a Good Samaritan concept. We're here to help. We may not be able to bandage all of your wounds right now. But we're working on it. That biblical narrative talks about the Good Samaritan that actually picks someone up, took them to a place of care, if you will. He could not stay there to care for them but he took them, steered them into the direction, took them to a place where they could get care. And I see that same concept with research, they may not be able to remedy the problem right now. They may not be able to stomp it out right now. But at least they have helped us to go to a place where we can stay focused and we can get some help there. And then they'll come back. And will check on us.

Rev. Burton's final comments exemplified the expectation that the relationship is ongoing. Investigators and universities were described as having resources and access that could benefit the faith communities as relationships were established and maintained.

Rev. Burton was emphatic that

anyone who wants to do research here at [my church] must understand that once you have partnered with us we expect certain things from you. We've given you our time and our talents. And so we expect to have something in return. We need to be able to pick up the phone and say, 'We have a concern about healthy hearts...Where do we go?' You know these other places that we, even if we google it we will only get so far. But there are some underlying layers that in research that you know about, that we might not have access to...We need to know where can we get grants... even if part of the research involved helping us write the grant. The overall result would be phenomenal for the research as well as for the church because it will be a way of following it. And you will have invested and we will have invested.

Dr. Pierce spoke of her continuing connection with the investigator who worked with her church. "We still consider ourselves as being in a relationship with her. In fact, we're

still going to do some things.” These ongoing relationships were characterized as having benefit to both parties. “It's a win-win for everybody.”

Barriers to Pastoral Participation

Pastors' perceptions of the barriers to personal participation in research varied widely among the participants. The only common theme across participants was the issue of their time. However, the general sense was that any barriers, even time, were manageable and arrangements could be negotiated to minimize those barriers.

Time.

Time was a potentially significant barrier to participating in research. However, participants generally felt that they could arrange their schedules and use volunteers to accommodate some level of involvement in research. For example, Dr. Walters said, “So my time is very valuable. But I'm willing to make time if I think it's beneficial for church people that I serve. So I am strapped for time but I always try to lend my time to worthy causes.” Reverends Thomas, Richardson, and Lewis would limit their personal involvement and rely on volunteers to carry the bulk of the responsibilities because of the demands of their positions as senior pastors. Rev. Thomas spoke of time as one of three major barriers to participating in research—privacy, time, and methodology. Time was the least impactful of the three barriers because he envisioned himself being involved on a limited basis. “But since I don't plan on getting that directly involved. I'll frame it for the congregation and encourage and that kind of thing. But it's more their [volunteer's]

time.” Rev. Richardson felt he could not personally participate in research as research was “just something to add to our plate”. Finally, Rev. Lewis echoed those sentiments in his comments that “my commitment was certainly, had its parameters. And they were somewhat limited because my plate is full.” Similarly, Rev. Douglas holds two ministry positions and her time is at a premium. She spoke of how she was grateful that her involvement in a research study was limited. “I was not, you know, like step by step...I really didn't have the time to say, ‘We're gonna come up with some listening tapes and I need you to come and help us, tell us what.’ I don't have time for that.”

Rev. Edmunds presented his suggestion for how to deal with the barrier of time. He felt that grants that require a significant investment of clergy members’ time should incorporate funding to hire an assistant to compensate for the time the clergy member invests in research. He was the only participant to suggest that grants should provide financial remuneration for time spent on research. He felt that funding should be made available “to make sure there is appropriate salary support for the amount of time that the organization puts into it. Whether it be the director or somebody to... an administrator or coordinator.”

Other Potential Barriers.

Two participants mentioned that endorsing a study creates a risk to their personal credibility and established relationships. They felt that they had to be very comfortable with a study in order to provide an endorsement. A denominational official framed his comments in terms of his relationship with congregations throughout the denomination.

“Because there is some risk involved, if it doesn’t go well, the people are turned off by it, you sort of lose some of, you know, so there’s a little risk in it.... That's why I said we... had to be comfortable that it was something that people would see the benefit in, and in the long run still not damage the trust relationship we've built over many years.” Dr. Pierce spoke of her efforts to ascertain information about the study in which she participated in order to provide her endorsement of the study. She outlined how she overcame this potential barrier to participating in a study.

For here, it's a matter of trusting me. And any church, especially the Black church, if they trust their pastor and their pastor trusts the university, then it will happen.

Int: So really it's about you putting your credibility on the line?

Res: Right

Int: So you have to have a very trusting relationship.

Res: And that's why I met with [the researcher], making sure, once I was satisfied. Asking the questions I know might possibly be asked of me. But when I stood before the congregation asking for a core group, asking for volunteers, then I'm perfectly comfortable that this is something that we ought to do, something we should do, that we must do.

The administrative cost of participation in a study was a concern for two participants. They both felt that the grant should provide funds to compensate for staff time or facility usage. “Because our education, our Christian education ministry still has to go on. If we're pulling from that to bring the participants to the table and to help logistically put things into place, certainly, to be, the use of a classroom for your research, if you need the whole floor, that we would feel that should be written into the grant... Those things should be taken into consideration. Church usage. Not necessarily

individual. But the usage of the church to be written into a grant form.” Rev. Edmunds focused on salary support rather than space. Both of these participants felt that this barrier was one that could be addressed.

Challenges to Congregational Participation

Fear.

Fear of self-disclosure was a strong theme related to the challenges of getting people to participate in research, particularly in the African American community. Some participants framed these fears in the context of historical and current racism. Rev. Edmunds contextualized these fears and reticence to participate in research in terms of the experiences of African Americans.

Historical fears... [people] have heard stories or have things in their mind. There's always a question, "Well, what will they do with it?"... Even when it's anonymous. They think they can trace it back to us. When you say, even when it's data that's very benign to us. One of the realities of being African American in cities such as [my city] that you do get sort of a persecution thing going on because over lifetime it happens so often. So you hear about, so it's not intentional on the part of persons who do that. They just have learned I want to be very careful about what I share. I might get hurt. Even in recent history, when civil rights. People had to be careful who they spoke to, or who they work for. They may not let a person know they had gone to a march or been at a rally or if they give some money to an organization supporting integration so the fear... Then in a place like [my city] when you have a research hospital that many people have grown to have a great deal of distrust for based on various things some factual some folklore. Some just misunderstanding, but it's out there. So there is that reticence to share among many people.

Rev. Lewis also spoke of the reticence to share information in terms of privacy and behaviors passed from one generation to the next. "African Americans, in my

observation, they're very private. They're not ones to open up and share their shortcomings, their challenges, and their issues. They're just not going to do that. They've had to manage, cope, you know, take it and keep it in. You know, not speak in certain company. Not speak if a certain person of another race enters the room. They've been conditioned to deal with that for generations.”

Fear appeared to be the major obstacle to congregational participation. Rev. Thomas felt that anonymous information would be more acceptable to his parishioners than identifiable information. “The big thing is folk have to be comfortable to share things that need to be shared depending on the nature of the study. And the other thing is whether you specifically identify persons or is there a way for their information to be anonymous, if you're just looking for categorization, and not looking for specific identification with persons. You know that's of the utmost importance in terms of folk being willing to share certain kinds of information.” Providing assurances of confidentiality and rigorous data management may allay some fear, but Dr. Walters felt that “everybody is a little reluctant. Answering questions about themselves. They're wondering how they are going to be seen or interpreted. And I think that's even more so in African American communities.” All the participants suggested that even requests for anonymous information might be viewed with suspicion although several participants felt that a pastoral endorsement would help in overcoming those suspicions.

Logistical Considerations.

Logistical considerations include space, congregational time, and the timing of activities. The issue of space such as available rooms for meetings was a potential problem for only one participant. His church has a very full activity calendar and space is at a premium. However, no other participants stated that space would be a problem for their churches. Even the pastor whose church meets in a school building suggested that they could accommodate research with appropriate planning. “The school—we've been here for 10 years—they work with us very well...It is a big restrictive. But the school has always been very helpful and amiable and accomodating to us.”

Parishioners' time was a consideration for some pastors but others did not see it as a concern. Those who did not see a problem have congregations that tend to be older with many retired members. Their time is more flexible. However, Rev. Thomas expressed a concern about his parishioners' willingness to participate because of their time constraints. “It just depends on how much time you need. If you're just doing a survey, in terms of like a questionnaire, I can get that done. But if it requires more in depth one-to-one contact. The timing of something.” He felt that studies that asked participants for more involvement might not be well received.

Dr. Pierce and Rev. Thomas both expressed concerns about the timing of study events. Dr. Pierce expressed concerns about scheduling events within the rhythm and flow of community life.

And a lot of times things can die because of the approach. With surveys and the

way in which you...if you are going to do quantitative data that you gotta understand the community. And how it is first presented. And the stages, if there are stages. Sometimes in our outreach we have to lay it out in stages because you cannot lay all of it out at one time. So I guess I will want to be involved. Just like the study was here, [The researcher] trusted me to present it to the congregation because, you know, people are in the communities here how they receive has to do with timing, has to do with place, has to do with who presents it. It doesn't mean that it's not good information but it can die before it ever gets a chance to live.

Rev. Thomas was concerned about using Sunday as a day to conduct research. He said, "Of course you see more folk on Sunday than any other time. But folk tend to think of Sunday as a period for worship and not a period of doing much else. They don't want to get involved and all that...and even though I can get certain things done from the pulpit in terms of after worship is over, getting folk to stick around and do something, that would be difficult." Rev. Douglas expressed an opposing view on the use of Sundays for research. "If you want to talk to African Americans in a large group, do it on Sunday morning, do it in the service." These opposing viewpoints suggest that investigators determine individual congregational preferences in this area.

CHAPTER 5

Summary of Findings

The findings of this study revealed a consistent view of health in holistic terms. The participants expressed a desire to be involved with health promotion research that has impactful, tangible outcomes. They also envision partnerships built on mutual respect. Studies should be well organized and fashioned to complement the mission and culture of the faith community. The participants' views of a manageable level of involvement varied. They identified seven roles that they might assume in a health promotion research partnership: (a) provide approval, (b) recruit participants, (c) identify volunteers, (d) lend influence, (e) keep information flowing, (f) spiritual teacher/educator, and (g) provide input on the study design. The primary benefits of participating in health research can be categorized as improved health and enhanced relationships with the university. Barriers to clergy participation were time, risking personal credibility, and the administrative costs of participating. Challenges to congregational participation included fear and logistical challenges.

Comparison to Corbie-Smith et al. (2010)

Corbie-Smith and colleagues (2010) used a grounded theory approach to exploring the roles African American clergy members might assume in health disparities research conducted in their churches. Corbie-Smith et al. identified 11 roles—(a) leader, (b) role model, (c) informant, (d) bridge, (e) spokesperson, (f) resource builder,

(g) empowerment specialist, (h) collaborator in study design, (i) organizational gatekeeper, (j) sanctioner, and (k) protector. This study identified several of the same roles, although their definitions may differ slightly. The concepts that evolved have significant similarities. The findings related to roles are discussed below.

While there are significant similarities between this study and the work of Corbie-Smith et al., significant differences also exist. The purpose of their study was somewhat more focused than this study. They targeted African American clergy members and specifically focused on health disparities research rather than health promotion research in general. Although this study was not specifically targeted at African American clergy members, the participant pool that emerged was comprised of all African American clergy and, therefore, addresses the perceptions of African American pastors. The methodologies of the two studies, although both grounded theory, differed. Moreover, the Corbie-Smith et al. study methodology used four focus groups of six to eight pastors while this study used individual, in-depth interviews with ten clergy members. Corbie-Smith et al. used geographic regions to select participants rather than the theoretical sampling used in this study. Perhaps more importantly, they did not seek out participants with research experience or exposure. Moreover, the participants in the two studies were comprised of different demographic characteristics as shown in Table 10. Most of the participants in the Corbie-Smith et al. study belonged to rural churches. The participants who work in one congregation (n=8) in this study were from urban or suburban churches.

The remaining two participants work with urban, suburban and rural churches throughout the state.

Table 10: Comparison of the Participant Pools of Corbie-Smith et al. and Foco

Characteristics	Corbie-Smith et al.		Foco	
Education	Advanced degree (Masters, Doctorate, or Honorary Doctorate)	57%	Advanced degree (Masters or Doctorate)	90%
Years at current church	Average	6.4	Average	12.7
	Range	1-21	Range	5-30
Years in ministry	Average	13.9	Average	25.1
	Range	2-47	Range	9-40

The participants in this study had nearly double the years of experience in the pastorate and in their respective churches. Perhaps more importantly, they had significantly higher levels of education than the participants in the Corbie-Smith et al. study. The additional exposure to educational opportunities may have influenced their perspectives of research. The Corbie-Smith et al. findings will be incorporated into the discussion of these findings.

Discussion and Interpretation of the Findings

Most Important Health Issues to Research

The health issues that clergy members perceived as important were those that impact their parishioners and the surrounding community. All participants indicated a desire to study health issues that significantly impact African Americans. The most often mentioned issues were (a) diabetes, (b) heart disease, and (c) cancer, particularly prostate cancer. Other issues that participants mentioned were HIV/AIDS, substance abuse, kidney disease, obesity, and hypertension. The personal knowledge and experiences of the health issues that impact African Americans reflects national statistics. According to the Office of Minority Health of the Department of Health and Human Services, African Americans adults are twice as likely to be diagnosed with diabetes as their non-Hispanic White counterparts (*African American profile - the office of minority health*). African American adults are 1.5 times more likely than non-Hispanic White adults to be hypertensive and African American men are 30 percent more likely to die from heart disease (*African American profile - the office of minority health*). The death rate ratio of African American to non-Hispanic Whites from prostate cancer is 2.4 (*African American profile - the office of minority health*). HIV/AIDS impacts the African American community at significantly higher rates than the non-Hispanic White community; African American men are 7 times and African American women are 22 times more likely to die from AIDS (*African American profile - the office of minority health*). These statistics

suggest that the health concerns raised by the participants are common to the African American experience (Office of Minority Health [OMH]).

The literature suggests that certain issues, primarily HIV/AIDS education, may cause tension among public health researchers and faith communities (Corbie-Smith et al., 2010; Francis et al., 2009; D. M. Griffith, Pichon, Campbell, & Allen, 2010b; Lindley et al., 2010). These tensions stem from differing preferences for messages related to sexual behavior (e.g. abstinence messages from the church vs. public health's emphasis on encouraging condom use). However, the participants in this study were generally supportive of addressing HIV/AIDS from a public health perspective. Their views were based in pragmatism; parishioners are dying from AIDS so it should be addressed in practical ways. While HIV/AIDS research was deemed important, they did, however, anticipate that their congregants would be reticent to participate in HIV/AIDS research. Studies are being developed that address these tensions and their findings suggest that successful HIV/AIDS education and screening programs and research studies can be developed through a collaborative process that encourages a sense of ownership on the part of the faith community (Francis & Liverpool, 2009).

The findings of this study related to HIV/AIDS research have implications for practice that echo, in part, the recommendations made by Francis and Liverpool (2009). Researchers who wish to employ this strategy should anticipate investing significant time, effort, and planning in collaboration with the faith community. The findings also suggest that the participants' recommendations for developing trusting relationships will

be particularly important if researchers want to address sensitive issues like HIV/AIDS education. Unlike Francis and Liverpool, the findings in this study suggest that leveraging the influence of the pastor is vital in engendering participation from congregants.

Substance abuse was another sensitive issue that was specifically explored with the participants. The participants suggested that substance abuse interventions such as Alcoholics Anonymous or Narcotics Anonymous are common in churches and, therefore, relatively familiar to parishioners. Participants emphasized that research related to substance abuse should clearly address confidentiality. Researchers should consider ways in which participation in the study can be kept in strict confidence (i.e. using a location other than the church building so participants are not seen by other parishioners). Also, the data security plan should be explained to parishioners to address concerns related to protection of their identities once the data are collected. Once again, the findings suggest that taking time to build trust with and understand the culture of the faith community becomes a crucial element of successful studies.

Mental health was the issue that most participants suggested would be difficult to address in the African American faith community. The participants felt that it was important to research but would be resisted by their parishioners. The predominant sentiment was that a stigma still exists among African Americans regarding mental illness. The findings of this study are similar to those of others (Brown et al., 2010; Conner et al., 2010; Hamilton et al., 2006). Feelings of shame or fear of being perceived

as “crazy” by other parishioners were among the possible reason for the anticipated resistance to mental health research in the faith community context. Moreover, Hamilton et al. and Conner et al. suggest that mental illness may be perceived as a lack of faith among some members of the African American faith community. The consensus of opinion among the participants suggests that mental health research may be unsuccessful in the African American church setting. However, a minority opinion began to emerge that attitudes regarding mental health are beginning to change among African American parishioners. The use of counseling services was presented as becoming more prevalent among African Americans. One participant recommended using professional counselors who are members of the congregation to champion and guide mental health research.

Definitions of Health

A definition of health expressed in holistic terms, as the data in this study suggests, appears regularly in the literature related to African American churches (Ammerman et al., 2003; Demark-Wahnefried et al., 2000; Kaplan et al., 2006; Rodriguez et al., 2009; Sadler et al., 2001). The concept of holistic health has been expressed by clergy who are not African American. A study of United Methodist clergy had a sample that was predominantly White (91%) (Proeschold-Bell et al., 2009). The United Methodist clergy said that “the participants defined health as, ‘wholeness of the spirit.’ ‘Mind, body, and spirit’, ‘a general sense of well-being’, and ‘spiritual, emotional, physical, mental well-being’” (n.p.). However, in a national survey of faith leaders, open-ended responses to questions about the link between spirituality and health revealed

a variety of perspectives (Webb, Bopp, & Fallon, 2011). The sample for this study was comprised entirely of Caucasian pastors from multiple denominations of Christian churches. Clergy members across denominations (Baptist, Lutheran, Church of Christ, Methodist, Lutheran, and Catholic) indicated that their doctrine was supportive of health promotion in the church setting. However, another perspective that their doctrine did not support health promotion activities in a church setting was expressed by a minority of respondents. These respondents suggested that the mission of the church is to minister to spiritual rather than physical needs and that, while health and wellness are important, they should be addressed in other forums. Research on denominational, racial, and other potential differences among clergy members' definitions of health and the appropriateness of health research in churches is in its infancy. Further research is necessary to create a more cohesive picture of the ways in which leaders from the broader faith community, from both Christian and other faith traditions, define health and how the faith community might be involved in health promotion research.

The dimensions of holistic health varied somewhat among participants. Six dimensions of holistic health were identified: (a) physical, (b) mental/emotional, (c) spiritual, (d) economic/financial, (e) intellectual/cognitive, and (f) social. However, the primary dimensions of spirit, mind, and body were consistently presented as the core dimensions. The secondary dimensions of health (economic/financial, intellectual/cognitive, and social) were portrayed as contributing factors to health or lack thereof in the primary dimensions. For example, economic hardships such as

unemployment might lead to depression. Moreover, the prevailing sentiment was one of balance. Spirit and body were seen as inseparable. Lack of health in one dimension lessens a person's ability to be healthy in other dimensions. As members of the clergy, the participants uniformly expressed that their primary concern was the spiritual wellbeing of their parishioners. However, the other dimensions of holistic health were seen as directly impacting people's ability to maintain a healthy spiritual life. This finding is echoed in Matthews (2006) where pastors were seen as responsible for the spiritual and physical health of their congregation.

Healing was portrayed as a result of prayer. However, they also embraced the notion that healing may be facilitated by traditional medicine. The participants indicated that they believe in the use of medicine and value physicians and medical treatment. Moreover, they discussed the importance of practicing healthy behaviors (i.e. eating a healthy diet, exercise, managing stress) as an important component in maintaining health. These findings suggest that health promotion research is congruent with the beliefs of these faith leaders.

The holistic understanding of health portrayed by the participants has implication for the ways in which health promotion research might be conducted in churches. The participants were open to the possibility of both research that is designed to incorporate spiritual content and studies that do not contain any spiritual content. However, they expressed that if a link to spiritual content was not explicit in the study design, the clergy members would create and present a biblical context for the study. They felt that any

activities conducted in the church setting needed a foundation in spiritual principles. These sentiments suggest that during the planning stages investigators may benefit from considering ways in which proposed studies might be linked with spiritual content regardless of whether spiritual content will be directly incorporated into the study or not.

Participants' personal or family health experiences (i.e. being a cancer survivor, having bypass surgery) and previous experiences with health ministries provided a framework for the ways in which they thought about health. Personal or familial experiences with health challenges appear to underscore the necessity of health research. This framework suggests that studies that fit with churches' ministry structures and particularly their health ministries may be viewed more favorably by clergy members. Investigators may find that clergy members will be more receptive to proposals for research if the study topics align with the activities of existing health ministries and can easily be incorporated into the flow of ministry that already exists. Another potentially desirable study design feature is are outcomes that have the potential to create a positive health impact across generations and ripple through both families and the community. This impact may be through a family (i.e. dietary changes learned by parents impact their children as well) or broader systemic changes that influence community health (i.e. community health fairs, health disparities research that influences policy decisions).

Partnership Structure

Approaching Faith Leaders.

Participants described three methods that researchers might use to approach clergy regarding participation in a study. They had experienced researchers approaching them through a) unsolicited letters, emails or phone calls, b) other staff members or volunteers, and c) pre-existing relationships with varying levels of effectiveness.

The data suggest that a multi-pronged strategy for approaching faith communities may be the most effective. The participants in this study who had not availed themselves of the opportunity to participate in a health-related study did so because they did not realize they had been approached and indicated they would have participated in the study had they realized what they were being invited to do. Persistence and multiple message channels may be necessary to bring a request for participation to pastors' attention.

The most effective method of establishing working relationships with faith communities seems to be pre-existing relationships. Researchers who plan to work with faith communities may benefit from investing time in building those relationships through service in the community and spending time in various churches. Service in the community has the potential to establish relationships with pastors who have common interests in social justice. Rev. Lewis recommended "that researchers seek African-American pastors who have demonstrated through their ministry an outreach of service and awareness that crosses socioeconomic, cultural, class, and religious 'boundaries', and

recognizes that the challenges that we face are 'human' challenges, that require 'human' solutions.” Several participants suggested that researchers attend services to develop a presence in the faith community. Moreover, being a regular church attendee and having a personal understanding of the faith community were seen as significant advantages when attempting to gain entry into churches to conduct research. The data suggest that the closer a researcher is to the faith community he or she is attempting to work with, the better the chances of gaining access. Dr. Pierce described the following characteristics of a researcher with whom she would most like to work. “Someone that is familiar with the church environment. And the female church culture I guess. Someone who has an appreciation for the church. You know, the things that we do. And someone that has good people skills.”

A Well-Organized Study.

Several participants expressed an appreciation for and expectation of a well-organized study. They view their time as important, and researchers who approach faith leaders with coherent, organized proposals are more likely to be viewed favorably.

These findings reflect the demanding nature of the life of a pastor and suggest that researchers consider ways to accommodate the demands of the ministry when attempting to elicit pastoral cooperation in studies. This recommendation echoes the recommendations of Markens and colleagues (2002). Participants in this study expressed a willingness to participate in research as long as it could be done within the context of

their other duties. A concise, well-organized proposal allows clergy members to assess a proposal for research quickly and determine its feasibility.

These findings present some challenges for Community-based Participatory Research investigators. CBPR employs a highly collaborative process in which community partners actively participate in the development of the study. These findings suggest that some clergy members may find the CBPR process requires a greater commitment of their time and energy than they may be willing to provide.

Meaningful Outcomes.

Participants in this study expressed that meaningful, tangible outcomes that benefit their congregations and community were critical to the decision whether or not to participate in a research study. This finding suggests another component of successfully engaging faith communities in research. The desired outcomes should be clearly stated in terms of the benefit to the faith community and/or its surrounding communities. The participants indicated that these benefits may be immediate or constitute one step on the road to long-term impact on health. However, the link between current research and the future benefits should be clear and easy to articulate to the pastors and their congregations.

Relationship with Investigators.

Participants expressed a desire to work with investigators who are willing to work with the community in meaningful partnerships. These meaningful partnerships include

(a) collaboration, (b) researchers investing time with the community, and (c) respect for community members.

Collaboration involves working together to accomplish the goals of the study. It involves working *with* community members rather than *in* or *for* a community. Collaboration was framed in terms of determining the goals of a study, providing benefits to the community, and establishing relationships. Working in collaboration with communities is a principle of CBPR (Israel et al., 2010; Minkler & Wallerstein, 2008). However, the findings suggest that clergy members expect to work in collaboration with researchers regardless of the level of community engagement. Participants expected some level of collaboration even if the research was community-placed research in which the church's functions were limited to provide a venue and recruit participants. The participants wanted to have some input into the study, although most expressed no desire to be involved in the initial planning. Researchers may encounter the challenge of two seemingly conflicting desires on the part of clergy—minimal time commitments and input into the design.

The willingness to continually spend time in and with the community was an important aspect of a productive relationship among researchers and faith communities. The participants emphasized the importance of an ongoing physical presence in the community as a means of developing relationships. Baskin et al. (2001) also recommended spending time with faith communities as a strategy for developing partnerships. Spending time in and with the community seemed to convey a sense of

valuing the community members as people rather than simply research participants. Spending time to develop relationships may be challenging particularly for researchers who are conducting community-placed research with the faith community as one of several venues. However, time the spent in the community speaks directly to the perhaps the most important aspect of successful partnerships—respect.

Respect for the faith community was seen as crucial to successful partnerships. Both respectful relationships with the individual researcher and his or her institution were suggested to be critical in successful partnerships. Lack of institutional respect was characterized by several participants as indifference to the plight of disadvantaged communities, taking from communities without “giving back”, failure to share resources, and as the product of a history of racism. Participants expected universities to actively and tangibly engage with the community to address these perceived indicators of lack of respect. This perceived lack of institutional respect for the community is an impediment that individual researchers need to overcome. The findings suggest that individual researchers can overcome the perceived lack of institutional respect through expressing personal respect for the community and the individuals who comprise that community. Researchers can express their respect for the community through a variety of actions such as worshipping with the faith community, attending broader community events, providing needed assistance to the community in the process of the research (i.e. grant writing assistance, employing community members as study staff), and maintaining ongoing relationships with the community after the conclusion of the study.

Roles, Benefits, and Barriers to Participation in Research

Overview of Roles.

The clergy members interviewed for the study identified several roles they could envision themselves assuming. They also indicated a desire for varying levels of involvement in research from only approving the study to involvement in the design of a study. The clergy members had assumed or envisioned themselves assuming several roles in a health promotion research study. The roles are (a) provide approval, (b) recruit participants, (c) identify volunteers, (d) lend influence, (e) keep information flowing, (f) serve as spiritual teacher/educator, and (g) provide input on the study design.

Preferred Levels of Involvement.

The clergy members in this study expressed a desire for various levels of involvement. The lowest level of involvement was described as approving the study and then delegating the church's responsibility for the study to others within the congregation. One participant indicated that he might consider becoming a co-investigator on a study, the highest proposed level of involvement. Most participants fell between those two levels with the majority expressing a desired to have limited involvement.

Two CBPR studies had significantly different findings related to level of pastoral involvement. Markens and colleagues' findings (2002) concurred with the preference for limited involvement expressed by the participants in this study. They found that in

order to recruit churches to participate in their study of dietary change, they had to intentionally limit the expectations they placed on the pastors and rely on others within the church to perform the required activities in the church. They attribute the need for limited pastoral involvement to other pressing responsibilities within the church. However, the Bronx REACH project had pastors more deeply involved in conducting the study (Kaplan et al., 2006; Kaplan et al., 2009). They did not discuss the reasons for the higher level of commitment involvement by clergy members in that study. However, the topics of the two studies differed. Markens et al. was a study of dietary change while the Bronx REACH project was attempting to address health disparities and health care access. The impact of the topic of research on pastoral willingness to become involved in a study is an area that warrants further research.

These findings may have implications related to preferred level of participation on the continuum of community engagement. Pastors expressing a high desire for structured, organized proposals may be more inclined toward community-placed or community-based research. These pastors expressed a willingness to do what needs to be done but no desire to participate in planning or making significant investments of time. These findings suggest that CBPR may not be preferred by all faith communities or their leaders. Only one participant in this study had previous exposure to CBPR and he viewed CBPR favorably. Other participants were reticent to commit that level of time and resources required for full CBPR participation.

Role Descriptions.

Seven roles that clergy members might assume in health research studies were identified through this study. These roles were (a) provide approval, (b) recruit participants, (c) identify volunteers, (d) lend influence, (e) keep information flowing, (f) serve as spiritual teacher/educator, and (g) collaborate on study design. The roles described by the participants in this study are consistent with the findings elsewhere (Ammerman et al., 2003; Atkinson et al., 2009; Corbie-Smith, Goldman et al., 2010). However, Corbie-Smith and colleagues (2010) in their study of the roles that African American pastors might play in health disparities research identified some additional roles that were not identified in this study. These roles were informant and role model. An informant was defined as “one who is viewed as a credible information source and lay expert on the initiative” (p. 826). The participants in this research did not view themselves as having sufficient expertise in health to be comfortable in this role. Corbie-Smith et al. (2010) specifically focused on health disparities research rather than promoting health more broadly. The participants in this study referred frequently to specific health conditions such as diabetes, cancer, and heart disease and their responses suggested that they did not feel they had expertise related to these diseases. While the literature suggested that serving as a role model for the study would be a role that the participants would assume, this response did not emerge from the data. Participants saw themselves as role models of generally healthy lifestyles (i.e. having a colonoscopy on local television or discussing the experience of having cancer from the pulpit) but did not

frame being a role model in the context of research. Perhaps this finding emerged from the participants' assumption that they would not be participants in the research conducted in their church, and their responses suggested that they would not have the time available to participate. They framed their influence in terms of speaking about the study rather than participation.

Identified roles.

The data suggest that pastors prefer a highly centralized approach to approving research proposals. The participants see the senior pastor as the final authority on making decisions regarding participation at the congregational level. The authority vested in the pastor of African American churches to make participation decisions is consistent with the findings in other studies (Ammerman et al., 2003; Kaplan et al., 2006).

Pastors saw themselves as assisting with recruiting participants and identifying volunteers for the study, primarily because of their knowledge of the individuals within their congregations. This appears to be consistent with the existing literature in which pastors were found to be crucial for recruiting because of their influence on the congregation (Ammerman et al., 2003; Baskin et al., 2001; Corbie-Smith, Goldmon et al., 2010). The pastors' knowledge of existing ministries and the volunteers within those ministries were considered an advantage in identifying individuals who would be effective in assisting with research.

However, recruiting was not a desirable role for one participant. A denominational official saw the time commitment required to develop the relationships necessary for recruiting participants as burdensome and a potential deterrent to partnering with health researchers. His position at the denominational level provides him a wider reach into more congregations. At the same time, it diminishes the amount of regular contact he has with potential participants. Proximity and regular access to the potential participants may be an influential factor on the ways in which the recruiting role might be perceived by clergy members who are considering engaging in research.

The findings of this study related to lending influence align with the previous findings in the literature. This study revealed that pastors consider using their influence to bolster participation in research as an important role. They viewed their leadership position as one of influence that could be leveraged to encourage successful participation. Ammerman and her colleagues (2003) had similar findings in which pastoral support and pulpit endorsements were critical to the success of their research. Similarly, Baskin and colleagues (2001) suggest that one of the advantages of working with Black churches is the influence of the pastor. They suggest that the general responsiveness to pastoral requests can be useful in the recruiting process.

Enabling the bi-directional flow of information between the faith community and the university was a role identified in this study and others (Corbie-Smith, Goldman et al., 2010; Markens et al., 2002). Pastors and other faith leaders are in a unique position to facilitate information flow. Senior pastors in particular appear to be in a position in

which they are aware of the overall activities of the church and can connect the appropriate individuals in need of information. Some pastors may choose to delegate much of the detail work of information flow to volunteers or other staff members as a means of facilitating information flow.

Clergy members indicated that they felt uniquely qualified to create and deliver messages that linked the study topic to spiritual or biblical content. The experiences of the Nashville REACH 2010 project echoes the notion that clergy members are the appropriate people to prepare spiritual messages related to health (Pichert et al., 2006). Nashville REACH 2010 worked with a local Bible college to develop a course on faith and health to prepare African American pastors to lead health programs to address health disparities. Four of the 13 classes were devoted to developing a theological foundation for health. Similarly, in the Bronx Health REACH project, a well-respected member of the clergy developed a *Theology of Sickness* for other clergy members to use as the basis for sermons in their churches (Kaplan et al., 2009). The participants in this study were willing to entertain spiritual content developed by researchers but maintained control over any spiritual or biblical content presented in their churches. These findings would suggest that researchers may be most successful in approaching churches from a position that allows the clergy members to generate biblical or spiritual messages. The participants expressed deference to the researchers' expertise in study design and knowledge of health. They seem to expect that same deferential posture from researchers vis-a-vis the spiritual content of the study.

The participants universally expressed that they would create biblical messages related to the study content regardless of whether or not spiritual content was part of the study design. The pastors expressed that their churches' primary purpose is to minister to the spiritual needs of their parishioners and community. This sentiment was not only universal but it was strongly stated. It suggests that researchers who can express the intent of their study to the ministry goals of the church will be better received than if they simply approach churches with a focus on physical health.

Participants indicated a limited interest in being involved in study design. This finding presents a different perspective than that found in much of the literature about campus/faith community partnerships (Corbie-Smith, Goldman et al., 2010; Kaplan et al., 2006). The limited nature of the desired involvement found in this study seemed to stem from three sources—lack of expertise in research design, limited knowledge about health, and lack of time to devote to research participation. Generally, the pastors deferred to the expertise of health promotion researchers for designing the studies. While expressing their knowledge of their congregations and communities, the participants recognized that researchers bring expertise in research design and knowledge of health issues that exceeded their own expertise in those areas. Finally, participating in research planning and design was seen as time consuming and beyond what was feasible given their already demanding schedules. This final finding is consistent with the experiences of Markens and her colleagues (2002).

Only one participant in this study has prior experience with CBPR and is the individual with the greatest amount of experience in research. He was the only clergy member who suggested that he would consider being a co-investigator. Perhaps his more extensive exposure to research has influenced his perceptions. The influence of previous research experience on willingness to be involved in research design is an area that may warrant further exploration.

Benefits

The benefits of participating in health promotion research can be divided into two categories— improved health and enhanced relationships among faith communities and the university.

Improved health.

Improved health involved tangible health outcomes. These health outcomes benefit either individuals or the broader community. Tangible health outcomes were not only a component of successful partnerships, they were portrayed as the primary benefit of participating in research. While any improvements in health were seen as beneficial, outcomes that have the potential to positively impact the health of African Americans and address health disparities were of particular interest to the participants. This finding suggests that researchers should make the potential benefits to the health of African Americans explicit in proposals to participate in research.

Enhanced relationships with the university.

Several participants suggested that a benefit of participating in research was enhancing the relationship among faith community members and university researchers. This enhanced relationship includes (a) an appreciation for the work of researchers, (b) a stronger sense of community and teamwork, (c) accomplishing more together than either could do separately, (d) leveraging resources for the good of the community, and (e) establishing ongoing relationships. The strength of these findings were unanticipated. The literature on partnerships among health promotion researchers and faith communities did not reflect the depth of the responses in this study (Ammerman et al., 2003; Kaplan et al., 2006; Markens et al., 2002). Each of these studies evaluated the partnership among the respective authors and the faith communities with which they worked. For example, Ammerman et al. surveyed pastors with whom they had worked on a CBPR study of dietary change. While the importance of various elements of working relationships with universities (i.e. communication, decision-making processes, and administrative processes) were rated by most respondents as *very important* or *extremely important* the researchers did not ask about the specific outcome of enhanced relationships with the university. The open-ended questions and absence of a tie to a specific study may have allowed these findings to emerge in this study.

The implications for practice are significant both for individual researchers and for academic institutions. Despite the backdrop of historic racism and a history of distrust of research, the participants in this study expressed a desire to enhance their

relationship with the universities in their area. They envisioned ongoing, synergistic relationships benefiting not only their community but the university as well. Further research is necessary to ascertain if the goodwill expressed by these participants is prevalent among other leaders in the faith community. The participants in this study were highly educated, perhaps creating a greater appreciation for the contribution of research than would be seen in the general clergy population.

Barriers to Pastoral Participation

Pastors' perceptions of the barriers to personal participation in research varied widely among the participants. The literature suggests that barriers to participation center on the clergy members' demanding schedule (Markens et al., 2002). Likewise, the only common theme across participants was the issue of integrating research activities into the participants' multiple time demands.

Time.

Time was a potentially significant barrier to participating in research. However, participants generally felt that they could arrange their schedules and use volunteers to accommodate some level of involvement in research. Some of the strategies suggested for dealing with the challenges of additional duties were to delegate duties to others within the congregation and to limit the types of activities in which the pastor involves him or herself. Another suggestion was to provide funding from grants that fund health promotion research to compensate the clergy member for the time invested in the study or

hire additional personnel to shoulder some of the responsibilities. However, this opinion was a minority opinion. Most respondents felt that they had sufficient volunteer resources to handle the additional duties. The findings have implications for study design, particularly in the design of the budgets for studies. It may be prudent to discuss the duties that investigators would like congregations to assume and, if deemed necessary, incorporate salary funds for either the clergy or others into a grant request. Williams and colleagues (2010) address this issue from the perspective of equal participation in campus/community CBPR partnerships. They found that participation in CBPR can be demanding on the resources of the community partner and recommended that those demands be taken into account in the grant writing process. When working with churches as with any other community partner, financial arrangements should be clearly delineated prior to entering an agreement to conduct the study (Ross et al., 2010). Alternatively, study designs may need to be sufficiently flexible to accommodate the demands on clergy members' time.

Other Potential Barriers.

A potential barrier to participating in research was risking personal credibility and established relationships by endorsing a study. The findings from Corbie-Smith et al. (2010) echo those concerns. Several pastors felt that they would be able to convince their parishioners to participate in a study. They specifically pointed to the high level of authority and influence that African American pastors have in their congregations. However, in a case in which a study does not go as planned, the credibility of the pastor

may be compromised. The participants felt that they needed to have great confidence in the researchers with whom they were working and in the study design. This finding suggests that investigators should invest time in answering questions and engendering the confidence of the clergy members with which they intend to work. Once again, establishing trusting relationships is a key to successful partnerships.

Generally, the barriers to clergy participation were perceived as minimal. Some participants envisioned no barriers at all while others felt potential barriers could be overcome with adequate planning and cooperation.

Challenges to Congregational Participation

Fear.

Fear of participating among parishioners was a theme that emerged from the data. The sources of these fears were rooted in a legacy of distrust and abuses by researchers and the health care system. These findings are similar to those of others. Both qualitative and quantitative studies of African Americans' attitudes about medical research and race indicate that the legacy of the Tuskegee syphilis trials and other historical research abuses of African Americans continue to influence attitudes (Corbie-Smith, Thomas, & St George, 2002; Freimuth et al., 2001). Maintaining data privacy, even if data were collected anonymously, was suggested as an impediment to recruiting participants. Similar themes have emerged in previous research (Kaplan et al., 2006; Kaplan et al., 2009; Markens et al., 2002).

The participants suggested several strategies for overcoming the fear of participation among their congregants. The influence of the pastor was the primary method suggested by the participants to overcome the fear of participating in a study. Pastors saw themselves as trusted individuals whose endorsement would calm the congregants' apprehensions about participating in a study. Secondly, spending time with the congregation and developing relationships with not only the pastor but other key leaders may help researchers gain the trust and confidence of the parishioners. As other key leaders express confidence in the process and in the investigators, the acceptance of parishioners may increase. Finally, communicating a transparent and well organized process is an additional step in developing a relationship with the congregation that may help to overcome distrust in research.

Logistical Considerations.

Logistical considerations include space, congregational time, and the timing of study activities and events. It appeared that space was not a major issue. Meetings and events are part of the regular flow of church life. As long as researchers understand and work within the regular protocols of the church, research can be accommodated without significant difficulties.

Parishioners' time to participate in research was a more significant concern. Onetime events seemed to be more likely to be embraced than studies that required attendance at multiple events, particularly for congregants with family responsibilities. Retirees were seen as more willing to spend time on research.

The timing of events was another factor. Church life has a rhythm and flow. Certain seasons of the year are busier than others. People are more likely to attend events on certain days of the week. The rhythm and flow of church life is different for each congregation. The participants indicated that research needs to work within the rhythm and flow of church life in order to be successful. These findings suggest that the anticipated time commitment and schedule of events should be carefully considered in the design of studies and discussed in advance with church leaders.

Emerging Models and Theories

The Social Ecological Model

The data suggest that health is enhanced or diminished in the context of the greater social milieu including family, church, and the broader community. The broader community influences on health proposed by the participants include historical and institutional racism, the educational system, the criminal justice system, social ills (i.e. drugs, alcohol, and gangs), employment challenges, and poverty.

The social milieu in which health is enhanced or diminished can be represented using the social ecological model (McLeroy et al., 1988). Church-based health promotion interventions have been similarly conceptualized using the social ecological model (Campbell et al., 2007). McLeroy and colleagues developed a model of health promotion that incorporated five levels of analysis for health promotion: (a)

intrapersonal factors, (b) interpersonal processes and primary groups, (c) institutional factors, (d) community factors, and (e) public policy. Figure 6 depicts the levels of the social ecological model and exemplar factors in each level that are presented in this study. The participants in this study addressed each of the levels in the social ecological model.

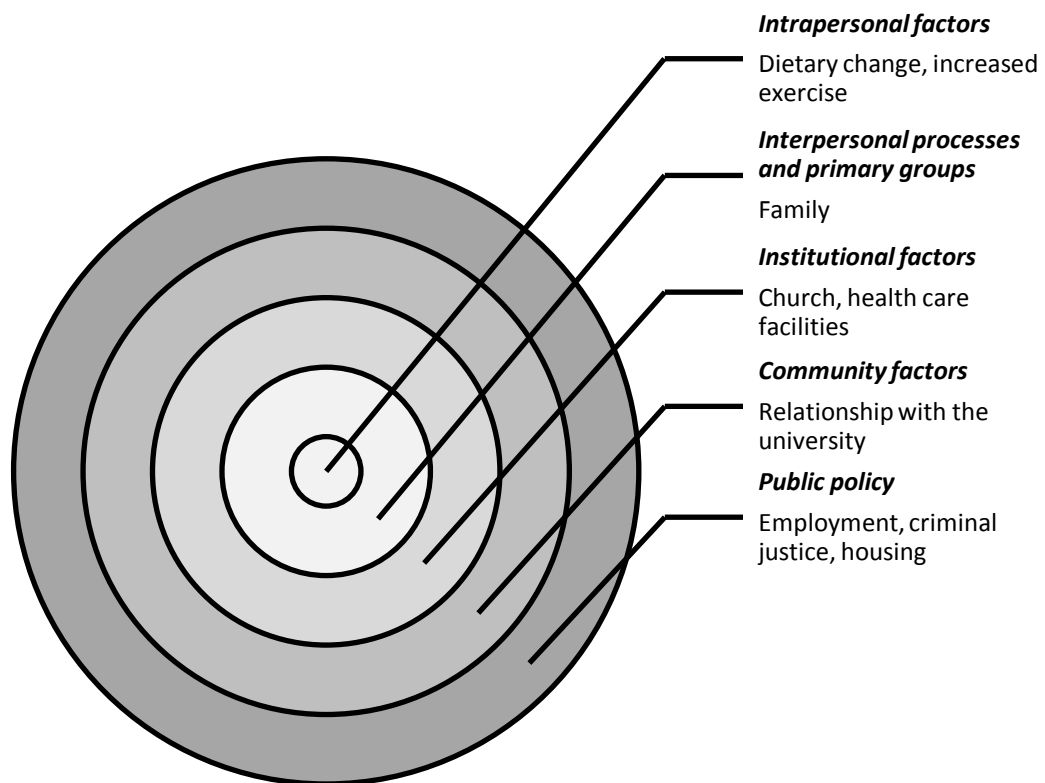


Figure 6: The Social Ecological Model and Health Promotion Research in Faith Communities

McLeroy and colleagues' (1988) social ecological model defines intrapersonal factors as "characteristics of the individual such as knowledge, attitudes, behavior, self-concept, skills, etc. This includes the developmental history of the individual" (p.

355)()(). The participants expressed a desire for health promotion research that would increase individuals' knowledge of disease prevention and management. Others spoke of changing individual behaviors such as improving dietary choices and increasing physical activity. Interpersonal processes and primary groups that provide social support and social networks were a major theme in the participants' interviews. Participants spoke at length of the importance of family influence on health. They framed families' behavioral influence on health as either a source of encouragement for healthy lifestyles or a hindrance to them. McLeroy et al. defined institutional factors as "social institutions with organizational characteristics, and formal (and informal) rules and regulations for operation" (p. 355)()(). Clearly, the pastors in this study viewed the church as an institution that has significant influence on the behavior of members. They spoke of behavioral norms related to diet and the influence the church can have on those norms through meals prepared at the church. Others discussed using the influence of the church to affect behaviors related to mental health and how the church may assist in removing the stigma of mental health issues. Community factors are "relationships among organizations, institutions, and informal networks within defined boundaries" (McLeroy et al., 1988). Relations among universities and the faith community were the most mentioned community factors in this study. The perceived quality of these relationships varied widely among participants but all expressed that collaboration with the university has the potential to help the faith community improve health. Finally, public policy was

mentioned by several participants in the context of addressing employment, criminal justice, housing, and other policies that impact health.

The social ecological model has been used in health promotion research conducted with faith community partners. One example used a social ecological model to address the problem of lack of fresh produce in a socioeconomically disadvantaged neighborhood (Baker et al., 2006). The researchers partnered with a local church to create a produce market in the church. They worked with individual behaviors and addressed social and economic factors within the community. The findings of this study suggest that clergy members would view such a study favorably.

Theory of Clergy Role Negotiation

Charmaz (2006) recommends coding data for grounded theory using gerunds to emphasize action. She further suggests that theories emphasize action and process. A theory of the development of clergy members' roles in health promotion research conducted in their church has emerged from the data in this study.

The data suggest that clergy members' involvement in research progresses through the research process. Pastoral roles are negotiated through a cyclical process that extends through several phases of the research process. Figure 7 illustrates a theory of the process conducting health promotion research in faith communities and of negotiating clergy roles and level of involvement. The research process involves several steps—(a) entertaining a proposal to participate in research, (b) deciding to participate, (c)

conducting the study, (d) concluding the study, and (e) maintaining ongoing relationships. The ongoing relationships may lead to further proposals for additional research.

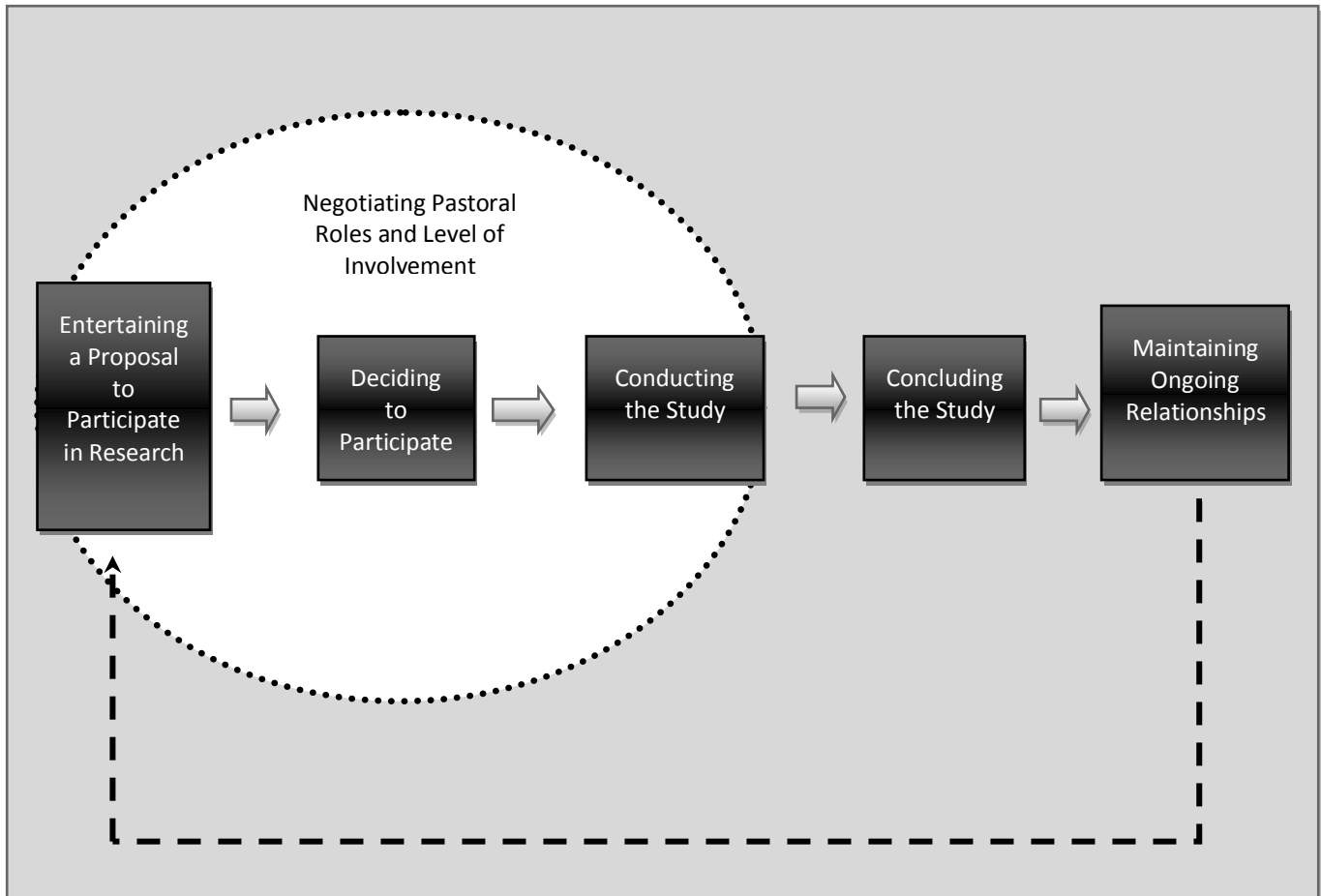


Figure 7: The Process of Negotiating Clergy Involvement in Health Promotion Research

The data suggest that pastoral role negotiations may occur anywhere during the first three steps of the research project. The level of involvement or roles may evolve and change during the process, particularly during the first three steps. For example, two

participants indicated that they would approve a study and then delegate the administrative details to others within the church. They indicated a clear preference for minimal involvement due to their demanding schedules. However, as the interview progressed, both indicated that they would consider other activities should their assistance prove valuable. One denominational official described his current involvement in a study during which his role has evolved and continues to evolve as the study moves from planning into active research.

The participants in this study indicated a preference for a well-organized proposal when being approached by a researcher. Several participants spoke of “making it easy” for them to participate. They expect that a researcher will have done his or her homework and be well prepared. This preparation includes being able to clearly articulate what the researcher expects the clergy member to do in order to facilitate the study. These initially identified roles form the basis for assessing the level of involvement requested by the researcher. They are a starting point for negotiating additional roles and greater levels of involvement.

These initially identified roles also form a portion of the information necessary to make a decision about participating in the study. Markens and her colleagues (2002) were required to reduce the level of involvement and roles that they had envisioned the pastors assuming in order to convince the pastors to allow their congregations to participate in their study. Some of the initial roles that Markens and her team had designated for the pastor were shifted to other church members. The findings of this

study suggest that other ministry responsibilities and time constraints are factors in deciding to participate in research. As long as others could be identified to perform the administrative duties, pastors indicated a stronger likelihood to participate.

Additional roles may be added during the implementation of the study. Participants in this study indicated a willingness to “do what needs to be done” to ensure the success of a study in their congregations. This willingness to help provides an opportunity to negotiate additional or expanded roles as the study unfolds. The findings suggest that the participants may be more open to performing roles in a study that are consistent with their current activities. For example, pastors routinely publicize church activities from the pulpit, making it an easy role to assume and more likely to be embraced. Creating spiritual content is another activity in which they already engage.

Pastors in this study expressed that they expect to be informed of study results as the study concludes. They saw reporting study results back to the congregation as an important function of keeping information flowing. They emphatically expressed that taking data and failing to report results back to the congregation was “unacceptable”. Open communication either through the pastor or his or her representative was seen as the basis for maintaining an ongoing relationship.

An ongoing campus/faith community relationship was portrayed as an important facet of participating in research. Reciprocity was an important element of these ongoing relationships. As Rev. Burton expressed, “Anyone who wants to do research here at [this church] must understand that once you have partnered with us we expect

certain things from you. We've given you our time and our talents. And so we expect to have something in return.” Researchers were perceived as sources of valuable resources and health information. These resources include grant writing assistance, connections to community health resources, access to current health information, and connections to other community organizations. However, similar to Ammerman et al.’s findings (2003) ongoing *relationships* were critical. Rev. Lewis expressed the importance of relationship. “African Americans we're relationship based... Before we can talk business, we're gonna sit down and you're gonna serve me some drink and I better drink that drink. And I better ask about your family and get to know you before we, if we ever do business on that day or on that trip, it's going to be predicated on my sincere interest and desire to get to know you as a person. And that's I mean that's just part of the African American culture.”

These ongoing relationships may form the basis for participation in additional research. The findings of this study suggest that a pre-existing relationship among the leaders of faith communities and university researchers enhance the possibility of the church participating in research. However, each opportunity for a church to participate in research has to be evaluated and negotiated individually. Ammerman et al. (2003) had similar findings. Their participants expressed an expectation that researchers from each study would need to go through a process of introduction and negotiation regarding potential participation. Previous relationships did not guarantee entry into the faith community.

The theory of the process of negotiating clergy involvement in health promotion research suggests some implications for practice. First, the findings emphasize the importance of establishing relationships with the members of the faith community prior to proposing research participation. While the importance of relationship varied among the participants, pre-existing relationships appear to be a preferred method of approaching faith communities.

Secondly, researchers should be prepared to negotiate the roles that clergy members may assume in their study. The demands that clergy members experience in their pastoral duties may require adjusting the researchers' expectations. This recommendation echoes Laken's (2007) recommendation that researchers enter partnerships with faith communities anticipating the need for flexibility in their plans and work strategies.

Third, researchers should consider ways in which individuals other than the senior pastor might be involved in the research. Researchers may benefit from spending time with the congregation to understand the flow and rhythm of life in the congregation and the ways in which the pastor is involved in the life of the church. An understanding of the health ministry or parish nursing ministry in particular may prove extremely valuable when proposing a structure for the study. Moreover, researchers should be prepared to adjust the clergy member's role during the course of the study. Participants mentioned the unpredictable nature of ministry. Pastors may be called away to attend to urgent matters on short notice. Discussing contingencies prior to an emergency may allow for

smoother operations in the absence of the pastor. Again, this may involve recruiting others within the congregation to perform some research functions during periods when the pastor must attend to other concerns.

Finally, relationships with faith communities should be built on respect for the mission and programs of the church (Atkinson et al., 2009; Kaplan et al., 2006). Health researchers and faith communities share a common commitment to social justice and service to the community (Gee et al., 2005). Showing respect for the assets that faith communities may bring to the partnership can be beneficial to establishing trusting relationships. One participant expressed his desire to utilize existing church activities to enhance research. “I would also share with the researcher the work that we currently do, the work we are involved in, and to even appeal to them as to how their desires and efforts can be enhanced by what we already have in place.”

Limitations

While qualitative inquiry is not designed to be generalizable, the composition of the participant pool for this study creates some limitations. This study was conducted in three metropolitan areas in one state in the mid-Atlantic region. The health promotion research being conducted in this area often focuses on reducing health disparities for African Americans. Therefore, the congregations that participate in research are predominantly African American. Research in other areas of the country with a different demography may yield different findings.

The use of emergent designs holds the inherent possibility for exploring unanticipated areas of inquiry. This study is an example of this phenomenon. Originally, this study was designed to explore the perspectives of clergy from a variety of Judeo Christian faith traditions. Moreover, the original intent was to recruit a diverse participant pool vis-a-vis race, gender, age, and ethnicity. However, the final participant pool reflects the reality of the state in which it was conducted. All participants were African American, over 40 years of age, and only one participant was not Baptist. The composition of the participant pool changed the nature of the discussion from general clergy viewpoints to the African American clergy perspective. The experience of being Black in a Southern state had significant influence on the findings.

The participants in this study are highly educated. Two participants hold terminal degrees in education (one Ed.D and one Ph.D) and three hold Doctorates in Ministry. Two participants are adjunct faculty members at a seminary. The level of education and involvement in higher education may have influenced their perceptions of research.

No clergy members who declined to participate in a study were interviewed. Their perspectives may have provided additional insight into why a congregation might opt not to participate in a study.

The perspectives brought by the researcher must be recognized. I must ask the reader to indulge me for a moment. It seems disingenuous to reflect upon the lens through which I have approached this endeavor while speaking in the third person. Therefore, in this small section of the document, I will write in the first person. As I

mulled over potential areas to research for my dissertation I followed the advice of my professors. They recommended that I choose an area in which I had a strong personal interest and knowledge. My area of concentration is health promotion and education, thus necessitating a focus on health promotion. As I read literature, particularly the literature related to reducing health disparities among African Americans, it became clear that the church was a frequently used venue for health promotion research. But little was written about the construction of the arrangements guiding those research activities. Churches and other houses of worship are familiar territory for me and I believe they can provide a viable venue for promoting health.

I have spent my life in church and have worked on the staff of one church. This familiarity serves as both a strength and a liability as a researcher. Prior ethnography is an important element of qualitative research. I had a knowledge base in church structures and theology. However, my background is in predominantly White Presbyterian, Lutheran, Assemblies of God, and nondenominational churches. The culture of the African American Baptist church has some distinctive features with which I was not familiar requiring an adjustment in my perspective.

Upon entering this project I had strong opinions about the nature of health and how it relates to spirituality. My approach to health has always been holistic and that holistic definition of health is not only grounded in the health promotion literature and my previous research but my spiritual beliefs. As a result, I made a concerted effort to

avoid influencing the participants' responses to questions related to their definitions of health and attempted to ask clarifying questions to avoid making errant assumptions.

In order for faith communities to participate in research, they must invest resources. I entered the study with questions regarding the relative value of health research vis-à-vis other activities of the church. My personal suspicions were that health research would be relatively low on the priority list. I have been surprised by the findings that research was more important than I anticipated it would be.

My personal background and previous knowledge had the potential to color my perspective as I conducted the research. In order to minimize the influence of my beliefs and knowledge, I have had to engage in a process of active reflection to separate my own prior knowledge from the participants' responses.

Conclusions

Research on the roles that clergy members may assume in these partnerships is in its infancy but Corbie-Smith et al. indicate eleven roles that clergy in African American churches may assume. Seven roles were identified in this study.

This study contributes to the discussion on clergy involvement levels in health promotion research. Unlike the inquiries that were linked to prior CBPR studies, the findings in this study indicated a desire for limited involvement in research (Ammerman et al., 2003; Kaplan et al., 2006). These findings concur with Markens and colleagues'

(2002) findings in which clergy involvement had to be limited to engender their participation.

This study proposes a theory of negotiating pastoral involvement and roles in research that extends the understanding of the process of developing research partnerships. This theory suggests that negotiation of clergy roles should be viewed as an ongoing process rather than a static event. The findings further suggest that researchers should approach clergy members with recommended roles but remain willing to negotiate these roles as the partnership progresses.

The findings suggest several steps that investigators may employ to enhance their working relationships with faith communities and their leaders. Invest time in developing relationships with faith communities and their leaders. Approach faith leaders using multiple communication channels and be persistent. “Do your homework”; be familiar with the culture of the faith community and present a well organized proposal. Incorporate a holistic approach to health in the study design. Discuss the link between the study and potential spiritual or biblical messages with clergy. Finally, discuss and adjust clergy roles as the study progresses.

The participants in this study expressed a positive attitude toward research. The findings indicate that clergy are willing to partner with health promotion researchers. Researchers who are willing to invest in ongoing relationships with faith communities and their leaders on studies that have the potential to provide tangible benefits can develop productive partnerships for health promotion research.

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APPENDIX A

Interview Protocol

I am conducting this study to meet the requirements for my Ph.D. through VCU. As you are aware, I am studying the role or roles clergy might play in partnerships between university researchers and faith communities. The purpose of this interview is to obtain your perceptions of health as well as your views of the health research projects in which you have participated or been approached to participate. In the interview you will have the opportunity to share ways in which you, as a leader in your congregation, have experienced and envision your role in health research projects.

Your answers will be confidential. Your identity will be protected in all written materials. Your answers will be combined with those of other clergy in the reporting of the study results. I do not foresee any risks to you or your congregation because of your involvement in this study. Your participation is strictly voluntary, and you may decline to answer any question. You may also stop the interview at any point that you choose. I anticipate the interview lasting approximately one to two hours. I will be sending/emailing you a copy of the transcript of our interview so that you can check it for accuracy and make sure the interview portrayed your thoughts the way you wanted. I will contact you with any follow-up questions after you have confirmed the accuracy of the interview transcript.

What questions or concerns do you have before we begin? If you have no [further] questions, I will turn the tape recorder on when the actual interview begins. I will also be taking some notes during the interview in case the tape recorder fails.

1. Tell me about your role as pastor/rabbi/priest/minister here at _____. What are your major responsibilities?
2. What is your definition of health? (Q1)
3. You have been asked to participate in this study because you have previous experience with university researchers who were studying a health issue. Please select one experience and tell me about it. (Q2)

Probes:

- a. Who approached whom? Describe your initial interaction with the university researcher(s). How did you feel about the initial interaction? (Q2) (b)
- b. Tell me about how the partnership was portrayed to you. In what ways was your actual experience in line with how the partnership was portrayed and in what ways was/is it different, if any? (Q3) (a, e, f)
- c. How would you describe the relationship the investigator had/has with you and with your congregation? (Q2)
 - i. Were you introduced by anyone? If so, whom? Did you know the university researcher(s) prior to being approached? If so, in what capacity? (b, e, f, g)

- ii. Did the university researcher(s) appear familiar with the culture of your congregation prior to approaching you or developing the project design? (e)
 - iii. Tell me about how the relationship changed/grew over the course of the partnership?
- d. Describe your role(s) in the partnership. (Q2)
 - i. Could you talk about a project as an example.
- e. Did the investigator have any expectations or make any requests regarding your role in the project? If so, what were they and how were they conveyed or determined? (Q2) (a, f)
 - i. Endorsement, recruitment, supplying space, other resources?
 - ii. Mutually discussed and decided, already determined by the investigator, decided on your own?
 - iii. Did they seem reasonable, realistic, attractive?
 - iv. Did your role(s) change over time? If so, how? How did the change(s) come about? How did you feel about the change(s)?
- f. Did you have any input into the content of the project?
- g. Into recruitment strategies? Other aspects?

- h. Did the project incorporate spiritual or theological content? If so, what was the content? How was it developed? Did it seem appropriate for your congregation? (h)
 - i. Were any unique aspects of your congregation's culture incorporated into the design of the project? If so, how?
 - j. In what respects did/does the project align with your congregation's mission and values? Are there any areas in which the project did/does not fit with your congregation's mission and values? If so, what are they and why did/do they not align? How did/do you deal with the lack of alignment? (Q1) (d)
 - k. Tell me about your decision-making process related to participating/not participating. How long did you take to think about it? What were the factors that made you decide to participate/not participate? Who was involved in the decision-making process? In what capacities? (Q2) (a, b, c, d, e, f, g)
 - l. How important is participating in health research in terms of the way congregational resources should be allocated, including your time and energy?
4. What were/are the benefits of participating in the study? (Q3) (c, d, g)
- a. Were/are they the same now as when you began the project? If not, how has your perspective of the benefits of participating in the study changed over time?

5. What were/are the barriers or challenges to participating in the study? (Q3) (a, b, c, d, f, g)
- a. Time commitment?
 - b. Scheduling?
 - c. Space or other logistics?
 - d. Using limited church resources?
6. Imagine that a team of health promotion researchers came to you and said that they had funding to do some research addressing a health issue in your congregation or community. The health issue(s) and structure of the research partnership are quite flexible. They have asked for your input on how to move forward.
- What health issues would be your top priorities to address? Why are these issues important to you? (Q1) (c, d)
 - If you could design a partnership between the university researcher and your congregation, what would it look like and what would be your ideal role? (Q2) (a, f)

Probes

- a. How might congregational resources be allocated, including your time and energy? (Q2 & 3) (a, d, e)
- b. Describe the amount and type of control you would like to have in the partnership? (Q3)

- c. Describe the flow and rhythm of congregational life and ways in which participation in a research partnership might be incorporated into that flow and rhythm to make participation easier for you and your congregation. (f, h)
 - d. What resources would you expect the project to provide your congregation? (Q2) (b, d)
 - e. What are some concrete ways in which university researchers might establish and maintain your trust and the trust of congregational members? (b)
 - f. What results would you like to see for your congregation and/or your community? Why are these important to you? (Q1) (c)
 - g. How might the partnership be organized? (Q2) (a, d, e, f, g, h)
 - i. What is the best way to communicate with the researcher?
The research institution?
 - h. What would be your concerns about entering into such an arrangement? (Q2) (a, d, e, f, g, h)
7. Do you have any other thoughts or comments you wish to share with me?

Thank you for your time.

APPENDIX B

Demographic Survey

Congregation Name _____

Date Completed _____

This section of the survey asks for some basic information about you as a leader in your congregation/denomination.

1. What is your age?

☐ 35 or younger

☐ 35-50

☐ 51-64

☐ 65 or older

2. Gender

☐ Male

☐ Female

3. Ethnicity

☐ Hispanic/Latino

☐ Not Hispanic/Latino

4. Race

- ☐ African American/Black
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other

5. Education Level

- ☐ Less than high school diploma
- ☐ High school diploma or GED
- ☐ Some college
- ☐ College degree or higher (Please specify advanced degree)
- _____

6. Are you currently employed in any capacity outside the church?

- ☐ Yes, full-time
- ☐ Yes, part-time
- ☐ No

7. How many years have you been in the ministry?

- 8. How many years have you served in your current role?**
- 9. Please provide a brief history of your partnerships with health researchers.**

This section of the survey provides general information about your congregation.

10. Approximately, how many people are members of your church/denomination?

- ☐ Less than 100
- ☐ 100-499
- ☐ 500-1,000
- ☐ More than 1,000

11. What is your faith tradition or denominational affiliation?

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Baptist | <input type="checkbox"/> Nondenominational |
| <input type="checkbox"/> Catholic | <input type="checkbox"/> Pentecostal |
| <input type="checkbox"/> Episcopal | <input type="checkbox"/> Presbyterian |
| <input type="checkbox"/> Jewish | <input type="checkbox"/> Seventh Day Adventist |
| <input type="checkbox"/> Lutheran | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Methodist | _____ |

12. Approximately what percentage of your church/denomination is in each of the following racial/ethnic groups?

Ethnicity

_____ Hispanic/Latino

_____ Not Hispanic/Latino

Race

_____ African American/Black

_____ Native Hawaiian/Pacific

_____ American Indian/Alaska

Islander

Native

_____ White

_____ Asian

_____ Other

Thank you for taking the time to complete this survey. If you have any questions, please contact me at 804-543-6326 or focorl@vcu.edu. I will collect the completed survey from you on the day of our interview.

Rebecca Foco

APPENDIX C

Interview Duration and Location

Interview Number	Location of First Interview	Length of First Interview (minutes)	Length of Second Interview (minutes)	Second Interview Method
1	Participant's office	70	14	Phone
2	Conference room at participant's church	48	12	Phone
3	Lobby of school that is used as the church's meeting place	22	22	Phone
4	Conference room at participant's church	26	13	Phone
5	Conference room at participant's church	28	25	In person
6	Pastor's office	43	8	Phone
7	Pastor's office	34	7	Phone
8	Church computer lab	63	Email	Email
9	Classroom at church	30	Email	Email
10	Participant's office	80	None	None
Total Time		444	72	

APPENDIX D

Axial Nodes and Coding Statistics

Node	Definition	Number of Sources	Number of Coding References
Access	Challenges investigators face in trying to gain access to pastors and congregations.	3	4
Administrative costs of participation	Grant support to cover administrative costs-- space, salaries, overhead	3	7
Approached	How, why and when approached by researchers. Includes by whom.	17	92
Approver	Clergy serve as the individual with the authority to approve or disapprove the conducting of a study in the church.	9	17
Attitudes about research	attitudes and perceptions about health research	11	29
Barriers to participation in research - Clergy	Clergy's perceived barriers to participation in research	7	7
Benefits - Congregational	Benefits of participating in research for the congregation members.	3	3
Building Trust	Building trust in the researchers and the university as a key element of a successful partnership	14	38
Challenges	Challenges that the clergy has encountered in participating in research	4	6
Characteristics	Characteristics of holistic health. Descriptors of health.	7	13

Node	Definition	Number of Sources	Number of Coding References
Christian health beliefs	Theological or spiritual beliefs that are based in the participant's Christian beliefs.	15	43
Clergy Role	Roles clergy indicate they have or would like to assume in a study	27	144
Clinical Trials	Research involving clinical trials.	2	6
Communication	Methods of communication used by and with the researchers and comments on their effectiveness.	5	11
Community Connections	Relationships with other community organizations outside the participant's own faith community	15	38
Community health issues	Health issues that are important to the community represented by the church (i.e., African Americans)	20	63
Connection with the broader community	Participating in research demonstrates a connection with the university and others in the community.	6	11
Culture	Familiarity the investigators had with the culture of the faith community	19	49
Decision to participate	Comments related to making the decision to participate in research. Who does it? Who assumes that role?	20	34
Definitions of health	Clergy member's personal definitions of health.	23	41
Disappointing results	We didn't get the results we wanted	1	2
Dream study design	Clergy's ideas related to how to construct a study to address the most pressing issue he or she sees for his or her congregation	13	32

Node	Definition	Number of Sources	Number of Coding References
Everyone's voice	Clergy members' desire to have all segments of society represented in research. Those at the bottom of the economic scale often don't have a voice.	5	8
Example studies	The study or studies used as an example in the interview.	9	55
Expectations of Researchers	Behaviors in which clergy expect researchers to engage	6	19
Fatalism	Belief that death is inevitable. Efforts to engage in healthy lifestyle choices will not be beneficial because "I'm gonna die with something."	1	2
Fear of being seen	Fear of being seen by other congregants and having them spread the word about one's participation.	5	9
Fear-congregational	Fear of participating in research. Code includes various reasons for that fear.	8	16
Flow and Rhythm	Ways in which research might be incorporated into the rhythm of congregational life	5	11
Follow up	Clergy expect researchers to follow up with the congregation after the study has concluded to provide ongoing support and present findings.	6	8
Good Fit	How well does the research study fit with the mission and goals of the faith community and church life.	8	19
Grant funding assistance	Clergy expect help with writing grants	6	9
Guinea pigs	Objections to participants being used for data gathering and then abandoned	6	6

Node	Definition	Number of Sources	Number of Coding References
Health promotion research	Type of research is health promotion. Includes intervention and data gathering research.	1	4
Helping People	An anticipated outcome of research. Direct or long-term benefit to people.	6	14
Holistic	Definition of health and/or ministry that addresses the whole person through a multidimensional approach. Dimensions include spiritual, physical, emotional, economic, and social.	13	19
Homework	Researchers should "do their homework" prior to entering the community.	3	9
Keep information flowing	Clergy keep information flowing from research to congregation and back.	8	11
Knowing your own group	Learning more about the health of your own group, (i.e. African Americans, Hispanics, women). Participating in the creation of beneficial science.	4	4
Lack of knowledge of research	Lack of knowledge about the research process--data usage, general process, benefits	3	4
Lack of respect	Researchers do not respect the clergy members. Treat them as subjects.	2	4
Lend Influence	The clergy member serves as a bridge between the researcher and congregants or introduces the project to the congregation and provides his or her endorsement for the study. Doing whatever is necessary to make the study a success.	14	36

Node	Definition	Number of Sources	Number of Coding References
Level of involvement	Description of the level of involvement the clergy member would like to have in a research project.	15	24
Logistics	Logistical challenges include space, scheduling, etc.	9	13
Make it easy	Clergy's desire that participation be simple and easy to do. Expect the researchers to have thought through the details.	4	8
Ministry Responsibilities	Major responsibilities in day to day ministries.	25	69
Networking	Pastor sees him/herself as a link between various individuals and entities in the community.	4	9
Organization mission and goals	Mission statements, goal statements and other documentation and comments that reflect the general organizational mission and goals.	17	25
Organizational Structure	Organizational structure of individual churches or umbrella organizations	15	39
Other Church Members' Roles in Research	Ways in which people other than clergy within the church are or can be involved in research.	15	35
Partnerships	Partnership arrangements for health with which the congregation or umbrella organization is involved.	12	57
Passion or Interests in health	The clergy member's particular passion or interest area within health. Why is he/she interested in health?	16	35
Pastoral Leadership	The importance of pastoral leadership in the congregation.	6	8

Node	Definition	Number of Sources	Number of Coding References
Perceptions of the university	Perceptions of the university as a partner.	13	31
Pre-existing relationships	Importance of pre-existing relationships to gaining entry into a congregation	8	21
Priority of Research	Relative importance of participating in research	7	10
Promotion vs. Research	A general lack of differentiation between health promotion activities within the church and health research.	3	4
Reaction to being approached	Responses and reactions to being approached to participate in research.	14	30
Reasons to participate	Reasons why a clergy member would want to participate in research.	7	9
Recruiter	Clergy see themselves as participating in future research as a participant recruiter.	10	20
Recruiting participants	General comments on challenges related to recruiting participants for studies.	3	6
Relationship with investigator	Formal relationship with the investigator/s.	8	20
Researcher characteristics	Characteristics of the researcher that were influential (either good or bad) in the decision to participate in a study	8	16
Risking personal credibility	Clergy must put their own credibility on the line to vouch for the investigator's credibility before the congregation.	3	5
Sensitive Topics	Any health issues or topics that would be perceived as too sensitive or inappropriate to address in a faith community.	11	31

Node	Definition	Number of Sources	Number of Coding References
So What	A tangible benefit that the congregation or individuals will receive as a result of participation in a study. At the very least, the "so what?" should be developing knowledge that will help others.	11	22
Social Justice Issues	Clergy's concerns that social justice issues be addressed in the research. Express concerns for the interests of the disadvantaged in the research process.	6	13
Sources of Definitions of Health	Clergy's experiences or beliefs that influenced how he/she has constructed his/her definition of health.	13	20
Spiritual or theological content	Comments related to the relative importance of spiritual or theological content in study materials	12	18
Spiritual Teacher	Serving as the person who provides the teaching on spiritual messages related to the study issue.	7	14
Spiritual Underpinnings	References to a spiritual, theological, biblical understanding of health.	13	22
Strategies-participation	Suggestions for strategies to overcome congregants' reticence to participate in research.	2	9
Study designer	Clergy would like to participate in the design of the study.	11	15
Study consistent with mission	Role of ensuring that the study is consistent with the mission of the church mission	4	4
Time	Time commitment on the part of the clergy member as a barrier to participating in research. Participating in research is labor-intensive.	6	12

Node	Definition	Number of Sources	Number of Coding References
Using limited resources	The importance of committing limited congregational resources to research	1	3
Volunteer Time	Concerns and barriers that volunteers may encounter when participating in a study.	5	8

APPENDIX E

Relationship among Themes and Nodes

Theme	Nodes
Pressing health issues to be researched	Community health issues Dream study design Sensitive topics
Definitions of health	Definitions of health Holistic
Dimensions of holistic health	Definitions of health Holistic
Sources of the definitions of health	Christian health beliefs Partnerships Passion or interests in health Sources of definitions of health Spiritual underpinnings
Characteristics of holistic health	Characteristics
Partnership structure	Dream study design Reasons to participate
Approaching faith leaders	Access Approached Pre-existing relationships Reaction to being approached
A well organized study	Flow and rhythm Good fit Homework Make it easy Organization mission and goals Study consistent with mission

Theme	Nodes
Meaningful outcomes	Disappointing results Fatalism Helping people Know your own group So what Social justice issues
Relationship with investigators	Building trust Communication Culture Expectations of researchers Follow up Grant funding assistance Guinea pigs Lack of respect Perceptions of the university Relationship with investigator Researcher characteristics
Roles	Clergy role
Preferred level of involvement	Level of involvement Priority of research
Provide approval	Approver Decision to participate Pastoral leadership
Recruit participants	Recruiter Recruiting participants Strategies – participation
Identify volunteers	Other church members' roles in research
Lend influence	Lend influence
Keep information flowing	Keep information flowing Networking

Theme	Nodes
Serve as spiritual teacher/educator	Spiritual or theological content Spiritual teacher
Provide input on the study design	Everyone's voice Study designer
Benefits	Benefits – Congregational
Improved health	Helping people Know your own group
Enhanced relationships with the university	Attitudes about research Connection with the broader community
Barriers to pastoral participation	Barriers to participation in research –Clergy Challenges
Time	Ministry responsibilities Time
Other potential barriers	Administrative costs of participation Risking personal credibility
Challenges to congregational participation	
Fear	Fear of being seen Fear – Congregational Lack of knowledge of research
Logistical considerations	Logistics Using limited resources Volunteer time
Background information not directly relate to a theme	Community connections Clinical trials Example studies Health promotion research Organizational structure Promotion vs. research

