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Faith Leaders' Experiences on Health Counseling Provided to Their Congregation

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This is to certify that the doctoral dissertation by

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Abstract

Numerous faith-based organizations (FBOs), denominations, and religious groups are represented in the United States. Faith leaders have the responsibility of addressing the spiritual needs of the congregation; however, the health needs of parishioners may be a point of discussion faith leaders should address. Communities surrounding FBOs may have limited health care services, lack transportation, and have serious health issues. The purpose of this phenomenological qualitative study was to explore the experiences of faith leaders on giving health counseling to their congregation. Faith leaders play an essential role in providing health counseling on various health topics to their congregation and community. A total of 15 faith leaders were recruited from 6 counties in North Carolina by convenience sampling. Face-to-face semi-structured interviews was the data collection method. The transformational leadership theory was used to examine how faith leaders motivate parishioners through constructs of the framework. Using NVivo, a qualitative data analysis software tool, the coded results indicated that faith leaders need specialized training to provide health counseling to parishioners about health issues shared beyond their field of expertise. The insight gained from faith leaders was important to understand the health-related resources needed to improve the health of parishioners. This study may be useful for faith leaders, public health educators, health policy makers, and researchers seeking to understand faith leaders' experiences; it could impact positive social change by providing resources and training needed to combat health-related issues within congregations.

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Dedication

I dedicate this dissertation to my loving and courageous mother Grace Elizabeth Davis, who was an inspiring single parent who raised two daughters and instilled in both, faith in God and education. She always encouraged me to complete my goals in life even on her deathbed, as I sat in her hospital room typing my fingers away beginning my 1st year of graduate school. She was a special jewel and will forever be missed. Her quote "He is the Sun and we are His flowers" will continue to live on as the sunflower was her favorite flower of choice.

I also dedicate this dissertation to my precious niece Gracen Cofield who will be about 10 months when I complete this process, and I want her to know that one day she will be encouraged to complete this same goal.

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I am grateful to the faith leaders who agreed to participate in this study, which could not have happened without their insight and wisdom. I would like to thank Dr. Precilla Belin, Dr. Frazier Beatty, and Dr. Kim Sanders for their guidance, which contributed to my success in completing this process. I also would like to thank my former manager Jennifer Smith who hired and supported me every step of the way to achieve this accomplishment. I appreciate my current manager Sue Anne Pilgreen who has also supported and mentored me through this process, by encouraging me to focus on my studies and by allowing me to take time away from work to complete my dissertation.

I would like to give special thanks to my dear husband, Martellis Dickens who encouraged me to stay focus and was there any time I needed him. To my Auntie Mom, Emma Dickens and Pastor who was there throughout the entire process by encouraging, praying, and giving me spiritual guidance. Also, I thank my sister Dazzala Cofield for her continued motivation and all the phone calls of support.

Last but never least, I want to thank God who is the head of my life for keeping me and guiding my footsteps. To God Be All The Glory!

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Chapter 1: Introduction to the Study

There are faith-based organizations (FBOs) along with churches that exist geographically throughout the United States, and many play an essential role in promoting healthy habits to the congregation and community (Anshel & Smith, 2014). FBOs have become very popular in providing an avenue to deliver health promotion programs to congregations, which often have a high attendance (Baruth, Bopp, Webb, & Peterson, 2015). Generally, 39% of Americans have reported attending church services more than 2 times a week, which offers a venue that may be appealing in delivering health information (Baruth et al., 2015). Although FBOs may be an appealing venue to offer health information to the congregation, faith leaders are often asked to give health advice and may lack training in this sector. For example, a member of the congregation meeting with the faith leader may ask if he or she should have a surgery or a medical procedure before it occurs. Faith leaders giving counseling to individuals on health-related problems concerning the person may be mentioned during a session. Faith leaders sometimes address health-related issues within their congregations because many communities have limited resources and FBOs serve as a facility where individuals can seek help concerning many health-related topics (Baruth et al., 2015).

FBOs reach people of multiple ethnicities and backgrounds, along with individuals who do not participate in traditional health programs due to the lack of resources (Baruth et al., 2015). Often, faith leaders are not trained to deliver health-related information to their congregation or community. Researchers have shown that faith leaders are not trained in seminaries to deliver individual or group health counseling

to promote healthy lifestyles behaviors (Baruth et al., 2015). According to Anshel and Smith (2014), faith leaders may not address various health-related issues, such as obesity, in an effort not to offend members of the congregation or community. This could be due to various FBOs historically having a strong association between religious organizations and food (e.g., church potluck celebrations, homecomings, and baked goods sales after church; Anshel & Smith, 2014). For some denominations, ethnic food is an essential part of the FBOs identity and is viewed as a sense of identity (Anshel & Smith, 2014).

Faith leaders in authority of FBOs are trusted by the congregation and the community, which gives them merit to encourage and promote positive behavior change. The health of the congregation is influenced by faith leaders, who should provide a healthy environment (Baruth et al., 2015). Although faith leaders have a strong influence over individuals in the congregation, many fail to take care of their health, which makes it hard for the faith leader to give effective health advice (Anshel & Smith, 2014).

Faith leaders who are equipped to deliver health-related messages may be ideal for the holistic approach in promoting spiritual, emotional, and physical well-being to members of the congregation (Baruth et al., 2015). According to Webb, Bopp, & Fallon (2013), faith leaders can provide health awareness tips and expectations to members of their congregation and offer important health education messages. FBOs and faith leaders play an essential role in encouraging the congregation about their role of eating healthily and practicing positive health behaviors to decrease health disparities (Webb et al., 2013). Faith leaders address issues on health care services, faith-based family planning, immunizations, prevention of human immunodeficiency virus, violence issues,

end-of-life issues, and mental health (Tomkins et al., 2015). Faith leaders may address issues that are above their knowledge; however, their parishioners may come to them with these concerning issues. In this study, I aimed to understand faith leaders' insights to recognize if they have appropriate training or resources to provide health-related information to the congregation and deliver health advice.

Background

The literature indicated that faith leaders play an integral role in providing health counseling or health advice to their congregation and community. Although faith leaders play a vital part in this role, not all leaders are licensed health professionals able to give health information to the congregation when asked to do so. Fallon, Bopp, and Webb (2013) claimed that faith leaders and health professionals should work together and be a resource to leaders and FBOs, as it relates to providing health counseling. Faith leaders often lack training and health resources needed to provide the congregation and community with information that is related to the illness one may be suffering from (Tomkins et al., 2015). Faith leaders are in the helping profession and obligate themselves to social change and social justice. This obligation of helping has occasionally been proven to have unfavorable results on their own health, including a reduction of exercise (Anshel & Smith, 2014).

There is a gap in the literature in understanding the difference between pastoral counseling and pastoral care among faith leaders (Hedman, 2014). Faith leaders assist members of the congregation in a one-on-one or small group format and often support members with handling crises or life problems, decision-making, and improving

interpersonal relationships (Hedman, 2014). These faith leaders are not mental health professionals and do not have the resources to solve problems that are addressed by psychiatrics/psychologists and social services agencies (Hedman, 2014). Faith leaders need training and mental health resources, along with health information, to be of service to their congregation. Researchers have indicated that faith leaders, clergy, and pastors can benefit from having pastoral counseling and clinical experience during their seminary coursework (Hedman, 2014).

The role and abilities of faith leaders to provide health counseling needs further exploration to be clear if leaders are viewed as gatekeepers. It is essential to know if faith leaders have the resources or guidance to refer individuals to health professionals (Fallon et al., 2013). Faith leaders, along with clergy, are supportive of health-related matters, and their beliefs, knowledge, and experiences are useful in providing health resources to the congregation (Bopp & Baruth, 2014). Researchers have shown that health-related resources at FBOs has a potential impact on the health of the congregation (Bopp & Baruth, 2014). There is lack of health promotion resources offered to faith leaders who attend seminary school (Bopp & Baruth, 2014). There is a gap in faith leaders leading the congregation with the lack of health-related materials that would allow them to be equipped to counsel members who need health information. This study was needed to obtain data on the experiences of faith leaders to provide future support to know what health resources and training are needed to evoke social change in the faith community.

Problem Statement

FBOs are vital to public health, and faith leaders play a role in providing health information to parishioners (Kehoe, 2016). This may be due to faith leaders having the dual role of health counselor and faith leader to meet the health needs of the congregation and community (Kehoe, 2016). However, many faith leaders do not have the proper training or skills to provide adequate health information to members of their FBO. Licensed psychiatrists, psychologists employed in the clinical setting, health providers, and health professionals traditionally conduct health counseling; however, faith leaders have been identified to fulfill an occupation in which they may have limited training (Fallon et al., 2013). Faith leaders interact with members of the congregation from sickness to well-being as it relates to the health continuum. Therefore, it is vital to know the level of training and resources faith leaders need to provide health counseling to parishioners.

Faith leaders serving in FBOs often assist underserved populations and those faced with inadequate health situations (Webb et al., 2013). Faith leaders may play a role in motivating the congregation choosing healthy behaviors and accepting health promotion interventions that may decrease health disparities in their congregation (Webb et al., 2013). The significance of this topic is important due to the number of individuals suffering from various health problems that are seeking health advice from faith leaders who may not have the proper resources to give accurate information.

Researchers have shown that involvement in health interventions among FBOs is an aspect of quality of life (Griffin, Kane, Taylor, Francis, & Hodapp, 2012). It is helpful

to know the experiences and insights of faith leaders by understanding what resources or interventions are needed in their congregation to promote good health in faith communities. FBOs may play a role in offering health interventions and collaborating with health organizations to promote positive health practices in the faith community (Bopp, Webb, & Fallon, 2012). Bopp et al. (2012) concluded that faith leaders could provide awareness and expectations to members of their congregation and offer vital health promotion messages. This shows that faith leaders have an influence in providing health information to the congregation. According to Bopp et al., there is limited research and a gap in the literature concerning the faith community's influence on current health statuses and public health interventions for congregations. While there is an abundance of literature on minorities and their views on health in the faith community and how to provide new strategies to engage them, there is limited research on the general community within FBOs (Cowart et al., 2010).

Purpose of the Study

The purpose of this phenomenological qualitative study was to gain an understanding of faith leaders' experiences on their role in providing health counseling to parishioners to improve the health and wellness of the congregation. In this study, I examined the barriers and resources needed to reduce health disparities and promote positive health outcomes in the congregation and community. Dekraai, Bulling, Shank, and Tomkins (2011) found that 1 in every 5 faith leaders has reported providing or supporting the following resources to the congregation and community: health education, health counseling, substance abuse resources, mental health problems, and behavioral

health disorders. In addition, I aimed to understand faith leaders' insights on various health-related problems affecting the congregation because faith leaders play a major role in serving as a gateway for many forms of community involvement (see Harr & Yancey, 2014). Providing the necessary resources and training to support the health needs of parishioners could lead to positive social change in the community.

Research Questions

The following research questions addressed the purpose of the study:

Research Question (RQ)1: How does motivating parishioners to achieve positive health outcomes influence faith leaders' role in health promotion?

RQ2: What are faith leaders' experiences as members of the clergy in providing effective health-related information to parishioners?

I also addressed the following subquestion:

RQ1a: What are faith leaders' insights of health-related issues affecting their congregation and the community?

Theoretical Framework of the Study

In this study, I used transformational leadership theory to examine features as they related to ways faith leaders can motivate their congregation to provide effective health information (Nahavandi, 2014). Transformational leadership theory is comprised of characteristics which incorporate factors to stimulate inspirational motivation and help leaders to be effective in achieving change within organizations (Ghasabeh, Reaiche, & Soosay, 2015). For example, this research may be useful to motivate faith leaders to influence change and provide health education through their sermons or offer health

interventions to low-income communities. According to Ghasabeh et al. (2015), transformational leaders are those leaders who can enhance organization performance, empower individuals, and enable change.

Transformational leadership theory was a suitable framework based on prior research conducted on this theory. Sosik, Chun, Blair, and Fitzgerald (2013) illustrated content of self-concepts that motivates faith leaders to display transformational leadership behaviors. Sosik, Zhu, and Blair (2011) also indicated that in faith community, leaders' are expected to role model their teachings and beliefs for followers. These two studies demonstrated how transformational leadership theory may play a vital role in motivating faith leaders and the congregation to promote changes in their health. Transformational leadership was beneficial based on the outcomes of the two studies mentioned, by embarking the faith leaders to have a commitment to their FBO and motivating the congregation to improve their health (Sosik et al., 2013). The faith leaders generated new ideas around health counseling provided to the congregation by offering a way to refer people to other health professionals based on the individual's health-related issues (Sosik et al., 2013).

Nature of the Study

The nature of the study was qualitative because this method allowed me to gather data in the faith leaders' natural setting. Qualitative researchers generally collect data in the participant's natural setting, instead of the individuals going to a lab or using survey instruments, such as survey research in a quantitative approach (Creswell, 2009). I conducted interviews with faith leaders in various regions of Northeastern North Carolina

(NC). This method was also appropriate because a qualitative approach aids to solve problems and often employs face-to-face interaction with participants in studies (see Creswell, 2013). The interviews were transcribed, along with responses coded and analyzed. The face-to-face interaction with the faith leaders helped me to obtain responses that I used to render essential data for the dissertation analysis section. A phenomenological approach was effective to gather data of faith leaders' views and experiences based on the phenomenon addressed.

Definitions of Terms

The following defined terms are used throughout the study:

Congregation: A group of people gathered from a particular religious worship who meet within FBOs or in the faith community (Dimitrova-Grajzl, Grajzl, Guse, & Smith, 2016).

Denomination: A form or type of religious group that is united in the adherence of its own beliefs and practices (Wirtz, Ngondo, & Poe, 2013).

Faith-based organization or faith community: A group of people who are represented locally, nationally, or internationally as a religious organization that shares specific sets of beliefs, along with having spiritual or religious principles (Tagai et al., 2018).

Faith leader: A person who is recognized within any denomination or religion organization who has some type of authority or power over the body of believers (Tagai et al., 2018).

Health-related issue or problem: Any condition that affects an individual's well-being and can cause a person to have pain or suffering, which is unwholesome to the body (Levin, 2014).

Parishioners, congregants, or members: Belong to a particular church or FBO in the local faith community (Chandra, Tyra, Idethia & Melicia, 2017).

Assumptions

According to Venkatesh, Brown, and Sullivan (2016), researchers should avoid research assumptions and must look for sufficient empirical evidence from theoretical statements. In this study, I assumed the following:

1. The faith leaders in the study were willing to participate in interviews and give their insights based on the interview questions prepared.
2. The faith leaders provided honest responses to the interview questions.
3. The interview questions were consistent with the qualitative study theoretical framework, which was the transformational leadership theory.
4. The data analysis and data collection procedures were effectively analyzed to render outcomes in the study.

Scope and Delimitations

In this phenomenological study, I expanded the understanding of faith leaders' experiences by learning what health resources and training are needed to promote positive health behaviors in their congregation. Convenience sampling was the selected method to sample the faith leaders in various regions in Northeastern NC. This form of sampling was selected to endure the inclusion of denominations of all faith leaders in

Northeastern NC (see Webb et al., 2013). Denominations within the region were selected through NC state-level denomination's governing organization that is associated with retrieving FBOs email addresses to request their participation in the study (Webb et al., 2013). The sample size was 15 faith leaders from the Northeastern region.

Limitations

It was important that the results from this study was validated, by considering issues that may have occurred to affect the validity and reliability. The validity of the study was ensured by giving the interview questions to other researchers or experts who work with FBOs to review and verify the interpretation of questions before the data were obtained (see Shilubane, Netshikweta, & Ralineba, 2016). The interview questions were also formulated on a reading level accessible to faith leaders, along with ensuring the language was easy to follow during the interview (see Shilubane et al., 2016). To ensure reliability in the study, I used an audit trail and detailed how the data was collected and analyzed, along with how the themes were derived from the results rendered in the study (see Shilubane et al., 2016). Each interview was recorded, and precise documentation was maintained with coding methods for data analysis (see Creswell, 2013).

To address the qualitative findings, transferability was one strategy I used to provide a detailed description of the target audience and obtain demographics within the geographic boundaries of the study (see Thomas & Magilvy, 2011). I describe this information clearly to provide other authors with data that can be used for similar methods in their research based on the topic addressed.

Confirmability was another term considered during the research process, which provided a sense of openness and awareness, based on the results from the study (see Thomas & Magilvy, 2011). To ensure confirmability as the researcher, it was imperative to provide a level of confidence with faith leaders as questions were asked, instead of leading the discussion (see Thomas & Magilvy, 2011). I also asked the faith leaders for clarification of any slang terminology, metaphors, or explanations that were not understood to ensure confirmability.

Significance of Social Change

The results of this study have the potential to close the gap related to the literature, by understanding faith leaders' experiences in providing information to the congregation and community about their health, through counseling. According to Hipple and Duff (2010), FBOs are uniquely placed to help deliver progress on many of the toughest problems. Faith leaders also are persuasive and influential in communities worldwide and have the power to make a positive impact to achieve many health goals in populations (Hipple & Duff, 2010). Faith leaders can influence positive social change because they can demonstrate encouraging health-related behaviors by serving as positive agents of behavior change in the congregation and the community (Hipple & Duff, 2010).

The findings from this study can enact social change based on the responses received from the faith leaders along with offering health care organizations and public health professionals data to understand the health needs of faith leaders in Northeastern NC. The study can give multiple medical organizations and health care facilities the opportunity to understand the many health-issues that exist in FBOs and how to provide

services or resources. For example, the results from this study may offer a medical center in the community the chance to provide faith leaders with a resource list of contacts when health counseling is beyond their expertise.

Summary

Faith leaders are often given the duty to provide health counseling for the congregation and need proper training along with health resources to provide effective health information to individuals. The ability to encourage positive healthy behaviors to their congregation is vital because faith leaders are often trusted by their congregation and community. Researching this topic was imperative to understanding faith leaders' experiences and to gain insight that can contribute to social change by informing health organizations of the particular support needed to offer heathy outcomes in communities and FBOs.

Chapter 1 included the introduction, background, the problem statement, purpose of the study, research questions, significance for the study, brief explanation of theoretical framework, nature of the study, definitions of terms, the general assumptions, the delimitations, and the limitation, and a summary. Chapter 2 addresses (a) the research related to content, including the role of faith leaders in providing health counseling, training, and the skills necessary to provide health-related information to parishioners and faith leaders' role in health promotion; (b) the methodology, including transformational leadership theory; and (c) the research related to both content and methodology, including more specifically faith leaders' insights on health and wellness to provide health counseling on various health-related topics to parishioners.

Chapter 2: Literature Review

Introduction

Health counseling is a robust approach that leads to improving an array of health problems (Fallon et al., 2013); however, there is limited research on its importance in FBOs and among faith leaders. In the research on FBOs, parishioners were found by Fallon et al. (2013) to be vital in the successful outcomes of health promotion actions. If faith leaders are formally trained and supported, when they are tasked to counsel parishioners on their health needs mentioned during a counseling session, perhaps it could result in positive outcomes for their members. Fallon et al. encouraged that formal training of these faith leaders to offer health counseling, which could result in their members changing perilous health behaviors.

In Chapter 2, I discuss the research related to content, methodology, including transformational leadership theory.

Literature Search Strategy

In the past 10 years, there has been an abundance of research related to this area of study, which includes the role of faith leaders on health and wellness, health counseling, and improving the health of their congregation or community. The search of the literature mostly included per-reviewed sources using Medline with Full Text, PubMed, Google Scholar, ERIC, EBSCOhost, and search engines through the Walden University library of Systemic Reviews, SAGE Research Methods Online, and SAGE Premier. The following keywords and word combinations were used to conduct these

searches: *faith leaders and health, clergy and health promotion, faith-based organizations and health promotion, faith leaders and experiences, religion and health,* and *health counseling*. In addition, the literature search included works published between 2007 and 2019. I aimed to select published articles within the last 5 years; however; I discovered large gaps in existing literature regarding my detailed topic. Therefore, I extended my efforts beyond a 10-year timeframe to capture relevant information about my study.

Research Related in Content

It is important to understand the roles faith leaders have in improving the health of their congregation. It is also imperative to learn the part religious leaders have played in providing health counseling to members in FBOs. In this section, I discuss research associated with the role of faith leaders providing health counseling, the need for health training on health topics, and faith leaders' role in health promotion activities.

Role of Faith Leaders in Providing Health Counseling

The current literature has not addressed viewpoints regarding faith leaders' skills to conduct health counseling or to provide health-advice guidance, which is vital to changing unhealthy lifestyle behaviors in the members served within FBOs (Bopp et al., 2013). Researchers have suggested that faith leaders participate in providing health-advice guidance, but little is known about their views of feeling comfortable in providing effective health information to members of the FBOs. It is also vital to consider if faith leaders have the resources and training needed to provide health counseling to members who ask for health advice. According to Fallon et al. (2013), "Health counseling is the

most commonly reported form of faith-based health interventions by faith leaders, nationwide" (p. 3). This quote shows that health counseling happens nationally, and Fallon et al. also reported that faith leaders found it important to succeed in learning the outcomes of health-promotion activities. Among FBOs, Fallon et al. found that health-counseling interventions have been proven effective in providing sound health education of parishioners. Researchers have also indicated that there are no observed studies to date that overtly address the barriers associated with faith-based health counseling (Fallon et al., 2013). Thus, in this study, I aimed to investigate faith leaders' experiences. Receiving faith leaders' insights to examine barriers may be helpful for the parishioners to receive the guidance needed during counseling sessions. Fallon et al. (2013) discussed findings that faith leaders reported that their own health insights played a role in offering health counseling to parishioners, which shows a need for them to be comfortable with their own health status in order to provide health advice to others. Ultimately, the best way to have the most effective faith-based health counseling is for faith leaders to be provided health counseling training programs to impact health behavior change (Fallon et al., 2013).

Headman (2014) discussed how counseling competency is a growing concern among clergy, and there is no set standard code of ethics guiding counseling practices, which is a barrier in the health sector. Additionally, clergy have expressed having limited resources in mental health, and this form of counseling exceeds their training and available resources (Headman, 2014). Clergy have communicated the need to build relationships with mental health professionals to health members in their congregation

with depression, along with treatment options available (Headman, 2014). If mental health professionals collaborate with clergy in providing resources, it may provide faith leaders with formal pastoral counseling training on various mental health problems. A review of the literature on faith leaders' experience with parishioners on depression revealed that there are more articles written with a strong focus on the elderly population or African American population (Headman, 2014). This information is pertinent to put the focus on a diverse population of faith leaders in this study due to the limited research that supports various denominations or ethnicities. Understanding the barriers that exist among clergy can address the problem with mental health professionals finding innovative solutions to reach FBOs to impact members in the congregation.

Bledsoe, Setterlund, Adams, Fok-Trela, and Connolly (2013) mentioned how clergy found satisfaction in their multifaceted role in providing counseling and crisis intervention to parishioners. Although clergy are full of gratification in counseling parishioners, many suffer from additional stressors, which include compassion fatigue, burnout, and emotional exhaustion (Beldsoe et al., 2013). Clergy and faith leaders play a major role in the work done for parishioners, and there is a sense of urgency that they do not become victims in trying to help others. Clergy are given multiple duties within a ministry and are required to counsel others; however, ultimately, they must make sure they take care for themselves so that they can fulfill their ecclesiastical duties. Clergy and health care workers both care for people who may be suffering from trauma or severe medical cases. When clergy meet the mental health needs of parishioners, it can be a main source of stress for clergy (Bledsoe et al., 2013). Clergy need to have full support

from medical professionals and mental health practitioners to direct them to the resources available for parishioners to have successful outcomes. Knowing faith leaders' viewpoints and if they have such support could be useful in this study.

There are various denominations and ethnicities within FBOs nationwide; therefore, is important to understand the role of faith leaders among diverse populations. Jo, Maxwell, Yang, and Bastani (2010) discussed the role of faith leaders in providing health counseling to parishioners from interviewing 58 faith leaders' perspectives working in Korean American churches in the immigrant community, which is an underserved group in the United States. Korean Americans face many challenges and often lack health insurance and access to care of vital health services (Jo et al., 2010). Faith leaders in the study expressed that parishioners were the first people to confide in them and disclose their illnesses, most often before seeking medical care (Jo et al., 2010). The need for faith leaders to provide health counseling to Korean Americans plays an essential part in giving parishioners resources for critical health services among the population. During pastoral counseling sessions, faith leaders expressed they not only provide parishioners with health counseling, but they also sometimes provide financial health counseling and address psychosocial needs (Jo et al., 2010). Though interviews conducted with faith leaders, it was suggested that programs be provided for the youth with an emphasis on alcohol, drug education, and counseling (Jo et al., 2010). Jo et al. (2010) were able to obtain faith leaders' perspectives to support future research that was helpful in understanding their role as church leaders, along with information to support this present study.

As it relates to the role that faith leaders play in the community, Opalinski, Dyess, and Grooper (2015) interviewed 13 leaders to explore if childhood obesity can be addressed through faith community engagement. Faith leaders expressed that the presence of fast food advertising is a contributing factor to childhood obesity and were deeply concerned of how they could provide rich health counseling or advice to parents (Opalinski et al., 2015). This information conveyed by the faith leaders shows that there is a need to find innovative ways to reach parents in FBOs to reduce childhood obesity, and more work needs to be done to combat this public health problem. Faith leaders also expressed that with the obesity issue, there should be an emphasis on societal and community aspects to consider what children are eating in school and the community's responsibility (Opalinski et al., 2015). Lastly, faith leaders voiced their role in offering awareness in the community to provide heathier food, spaces, and activities to find a holistic way to help children and their families (Opalinski et al., 2015). When faith leaders can address issues such as childhood obesity when counseling their parishioners, it can be helpful in their role to influence health behaviors in their congregation.

Training and Skills Necessary to Provide Health-Related Information to Parishioners

Training is needed, so faith leaders can deliver health-related information to parishioners and provide the proper resources to their congregation when giving health advice. The qualitative study by Baruth et al. (2015) explored how faith leaders have influence over their parishioners on health-related issues and the health information leaders are requesting to increase awareness in their congregation. The study involved 24

faith leaders by identifying through semi-structured interviews the top health challenges among their parishioners and their influence on their congregation's health/wellness issues (Baruth et al., 2015). Faith leaders mentioned various health issues including poor health behaviors, access to health care services, high blood pressure, stroke, diabetes, cardiovascular disease, and overweight/obesity among parishioners (Baruth et al., 2015). These health conditions noted by faith leaders directly recognized problems that require leaders' the need to possess skills and training to raise awareness in their congregation. Unhealthy lifestyle behaviors contribute to the leading causes of death and illness in the United States, therefore faith leaders are often the pillar to address these health-related issues during counseling or from the pulpit (Baruth et al., 2015).

It is vital for faith leaders to be comfortable in communicating accurate health-related information to parishioners and if they are not comfortable, have resources to give members of the congregation. Faith leaders who report better comfort in addressing parishioners about health, are more likely to offer counseling to members (Fallon et al., 2013), which supports Baruth et al., (2015) data of the influence of faith leaders on their parishioners health. This also means the faith leaders who are comfortable giving health information to parishioners, encourage the congregation to practice healthier lifestyle behaviors. If health resources are available to faith leaders in seminary school (Bopp et al., 2014; Bopp and Fallon 2011), possibly it would increase faith leaders self-efficacy to offer health counseling and/or referrals. Training on various health-related topics, perhaps will be essential for faith leaders who do not feel knowledgeable or comfortable in developing health information to parishioners.

The training and education among faith leaders differ based on various doctrines and traditions fostered among diverse populations. It is vital to understand the variance in training methods from seminary, which may vary across various religions. Kohoe (2016) review of literature captures research that determines faith leaders follow their own established ethical guidelines that differ across religious denominations, similar to health professionals. On the other hand, research indicates mental health needs of parishioners in the faith community far proceed the skills and training of faith leaders. This means faith leaders have cited paired roles of a counselor and faith leader, along with various faith articles (Nauert, 2014; Norrt, Braam, Good, & Beekman, 2012) noting the lack of adequate celery training to deal with chronic health-related issues and mental illness.

For example, an Imam leader counseled parishioners in a rural community until a couple met with her, and the women expressed concerns of dealing with serious depression for months, which was affecting her marriage and family (Kohoe, 2016). Because of the counseling session, the Imam leader had taken counseling courses in his training, however did not feel qualified to give advice the congregant suffering from serious depression and had no resources to help her (Kohoe, 2016). This research is an example the abundance of literature with information on faith leaders as it relates to training needed for mental health issues, but there are limited studies on the insight of faith leaders with other health-related topics, which expresses the need for this dissertation study.

Bopp et al. (2014) further examined clergy insights of the support needed at seminar school to provide health and wellness information to parishioners. Semi-structured interviews were conducted from 24 faith leaders representing from multiple denominations to receive their insights on the support training on health (Bopp et al., 2014). Faith leaders have a substantial influence on the health-related issues that are mentioned while delivering sermons or when counseling is given and health is the topic of discussion. Understanding their insights on having proper training during seminary of health and wellness is essential if it is not occurring. The results by Bopp et al. (2014) indicated a lack of support for seminaries to provide formal training on health-related issues across denominations and leaders noted the importance of making connection with health professionals, along with them providing sufficient resources. Faith leaders understand how the health of the parishioners is an important aspect for them to consider and it can affect their ministry if parishioners are unhealthy. The study revealed there is a link between health and the church level, which indicates a lack of infrastructure for seminary schools supporting health and health-related programing (Bopp et al., 2014). The results for the study indicated there is strong need for training opportunities on health-related issues to be offered at the seminary level to have positive influence on the leaders' health and parishioners.

Faith Leaders' Role in Health Promotion

FBOs, often bring people together at one time into a large audience, as an ideal approach to increase health promotion efforts (Baruth, Bopp, Webb, & Peterson, 2015). However, faith leaders can make a critical difference in the health of the people they

serve. Researchers clearly indicate faith leaders play a vital role and have strong influence over the members in the congregation, as it relates to promoting positive health behaviors (Baruth, Bopp, Webb, & Peterson, 2015). There is an abundance of studies on how health promotion programs have been implemented in FBOs; however, there is a gap in the literature. This gap is due to numerous articles on the role African American faith leaders play, which proves the need for this dissertation research covering multiple denominations and ethnicities. Exploring research on the faith leaders' role in offering health promotion programs and improving the health of their parishioners will add to the research.

Kruger, Lewis, and Schlemmer (2010), highlighted the implementation of the Mapping a Message for Faith leaders (MMFL) program, to empower the leaders to grasp community and personal health-related information, along with health promotion at a local level. A survey was developed as a method involving community-based participatory research (CBPR) to have broad topic areas on community and individual health, through random sampling households by use of census tracks. The overall goal of MMFL was to share pertinent information with faith leaders to identify issues of concern with them developing health ministries or sharing health information in the community (Kruger, Lewis, & Schlemmer, 2010). Faith leaders were given community-specific reports, which described the health of the residents living in the area surrounding their FBO, in an effort to develop health ministries and issues of concern in the neighborhood of whom they served (Kruger et al., 2010). This unique approach was different, because it gave faith leaders a chance to view neighborhood health reports and allow health

professionals and community partners to assist in improving the health of the parishioners and communities. This approach was interesting in providing a framework to connect religion and health, along with empowering faith communities as a mechanism to improve health outcomes and promote health promotion with use of CBPR methods (Kruger et al., 2010).

Williams et al. (2012) examined faith leaders' beliefs about health and the church health promotion environment through 40 interviews with pastors and 96 from members of rural churches. The qualitative study was effective in interviewing faith leaders into three categories: (a) views regarding sermons (b) views on having one-on-one health counseling (c) views regarding congregant receptivity (Williams et al., 2012). This information is relevant to understand the faith leaders' experiences to determine the FBO health promotion environment to recognize environmental domains. The results revealed that over half of faith leaders in the study thought it was right to talk about health eating during sermons, along with giving members information about physical activity and losing weight (Williams et al., 2012). However, faith leaders reported positive beliefs concerning talking to parishioners through one-on-one-health counseling about health topics. Williams et al. discussed that faith leaders major role is to act as a counselor to parishioners, and there is a need for leaders' to be better equipped to support a health promotion environment. This study determines the importance of researchers understanding faith leaders' beliefs are taken into consideration and health promotion interventions are design health programs. Generally, the greater faith leaders had

personal dedication towards health, the more likely they are to provide health counseling to parishioners on health-related topics.

To explore faith leaders views on the support needed to provide accurate health counseling to parishioners, it is vital to understand their view on receiving support from outside organizations, such as institutions. Through firsthand experience, it can take time for faith leaders to build trust and invite institutions within FBOs to begin research or offer support for health promotion programs. Bopp and Fallon (2011) examined the influence of health and wellness activities offered by institutions within FBOs to determine the support needed for faith leaders to offer health promotion to parishioners. This study was on the national level and convenience sampled 844 faith leaders through an online survey, to ask questions on institutional influence on outside support from health promotion professionals (Bopp & Fallon, 2011). This study was imperative due to the use of multiple religious denominations from various states were included in the study.

The findings indicated there are several influences that questioned the quantity of health and wellness activities offered in FBOs. It should also be highlighted for future faith-based establishments implement and offer faith-based health promotion initiatives (Bopp & Fallon, 2011). Faith leaders reported the need for more education on health and wellness, which would benefit parishioners. Bopp and Fallon also discussed how other professional degree programs and seminary schools could set goals to have curriculum aimed to improve faith leader health, therefore the health information can be pass to parishioners on health- related issues. This study is helpful in providing evidence on an

array of factors influencing health promotion programs offered by institutions and in FBOs, along with the health-related education in seminaries for faith leaders to promote healthy behaviors among parishioners.

Though FBOs are an effective setting to reach many people, it is interesting to understand if megachurches who attendance can reach 2000+ parishioners, can be the forefront for providing health promotion activities or programs. Bopp and Webb (2012) surveyed respondents to represent 110 churches, which were mainly Baptist, non-denominational, or from primary White congregation members. This study was more unique than other studies included in this section to gain an understanding of how the parishioners viewed the role of faith leaders in promoting health-related programs. The respondents were asked to report if the faith leader had focused on including health in their sermons, or providing counseling related to health and wellness. As a result, it was reported that only three churches offered health-related activities to parishioners and 19 responded that health was included as part of their faith leaders sermon (Bopp & Webb, 2012). The authors mentioned a focused effort to educate faith leaders in the megachurches on various health-related topics to support health interventions that benefit parishioners (Bopp & Webb, 2012). Respondents also reported the lack of financial resources to support health and wellness efforts Bopp and Webb (2012), which clarifies the need for this dissertation to continue understanding the barriers that FBOs face in providing health promotion programming.

Research Related to Methodology

The research related to methodology section includes the theoretical framework transformational leadership theory. Additionally, this section provides a description of the literature that used transformational leadership as the theoretical framework of their study.

Theoretical Foundation

Transformational leadership theory involves a focus emphasizing the relationship between faith leaders motivating the parishioners to promote positive health behaviors. This can be accomplished by the leader setting goals and tasks that allow them to lead in a way that causes followers to have similar focus and inspire them to improve their health and enact behavioral change. James Downton originally created transformational leadership, however the approach began to emerge from definitive work from a political sociologist James MacGregor Burns titled *Leadership* (Northhouse, 2018). Burns work originated in the political setting, however he could distinguish between two types of leaders': transactional and transformational. Transactional leaders are focused on identifying the need of their followers and includes exchanges that transpire between leaders' and their followers (Northhouse, 2018). On the other hand, this study focuses on transformational leadership, where the leader engages their followers needs and encourages them with a high level of motivation to exceed their fullest potential (Northhouse, 2018). It has been suggested that leadership practitioners and researchers agree that transformational leadership should be used to inspire followers and evoke innovative change (Nahavandi, 2014). This is helpful when proposing this theory to

inspire parishioners who are the followers of the faith leaders, to conjure positive health behaviors that to connect to a high levels of motivation to evoke change in the congregation.

There are four leadership factors of transformational leaders':

- The first factor is *idealized or charismatic leadership*, where leaders' act as robust role models for followers. These leaders are very respected by followers and develop a great deal of trust in them. This also refers to the acknowledgments of leaders made by the follower, based on beliefs they have towards their leaders'.
- The second factor, *inspiration* or *inspirational motivation* refers to leaders who are descriptive in communicating high expectations to follower, which inspires them through motivation to become dedicated to the organization's communal vision. Leaders' often do pep talks and use encouraging words to motivate followers.
- The third factor, *intellectual stimulation* includes the leader encouraging creativity in a setting that fosters followers to feel obligated to think of past problems in an innovative way. This type of leader provides a support system for the followers and encourages them to things through carefully, by problem solving.
- Finally, the fourth factor *individualized consideration*, leaders' serve in providing a supportive setting where they listen carefully to the specific needs of followers. Leaders' also acts as mentors and counselors, and the followers' needs are highly respected (Northhouse, 2018)

Transformational leadership theory embraces various concepts to guide faith leaders to motivate, and inspire parishioners to reach their fullest potential. In a research study conducted by Sosik, Chun, Blair, and Fitzgerald, (2013), transformational leadership theory was combined with possible selves theory to receive 184 faith leaders self-reported data on the following subcomponents: idealized influence behaviors and characteristics, inspiration motivation, intellectual stimulation, and individualized consideration. The study is significant because transformational leaders' in FBOs often have an approach to motivate parishioners on various topics that influence hope and optimism, which may be beneficial to faith leaders who counsel members of the congregation. This concept would allow faith leaders to build a strong relationship with followers (parishioners), which will involve growth in adapting positive health behaviors given to them through the leaders' sermons. The study results indicated that self-concepts to motivate faith leaders were those that reflected high level of transformational leadership (Sosik, Chun, Blair, and Fitzgerald, 2013). Sosik et al., noted the need to offer training interventions (Chun et al. 2012) to show pastors how to improve their mentoring abilities.

Rowland (2008) explored the effects of transformational leadership paradigm in testing the validity of its affects concerning Christian pastors, by using several outcome criteria. It is vital to study transformational leadership on faith leaders in order to increase knowledge of pastoral leaders' and understand the impact on followers' motivation and performance (Rowland, 2008). This information would be helpful for the present study to understand the value on faith leaders approaches in the pulpit, to view

how they can address the health needs of the parishioners. Rowland had two studies in one, where the first one addressed pastoral leadership behaviors on followers, and the second focused on the effect on the congregation, which represented 120 followers from 31 different FBOs. The results from regression analyses revealed that transformational leadership was positivity linked to with followers satisfied with their faith leader, their additional effort, their effectiveness, and their job satisfaction.

Additionally, the effect on followers as it relates to transformational leadership, also display positive effect on parishioner's satisfaction on the worship service (Rowland, 2008). This study perhaps will be useful in knowing the positive affects transformational leaders can have on faith leaders who counsel parishioners on health-related issues. The positive effects of transformational leadership on parishioners may allow them to communicate and perform well with members of the congregation. Furthermore, Carter (2009) described that transformational leaders among Protestant pastors encouraged effective parish operations, and Rowland (2008) found that congregations highly satisfied with such pastoral styles were willing to give extra effort for a fruitful congregation.

Carter (2009) used multiple variables through a questionnaire to understand transformational leadership styles in pastoral leadership, with ninety-three pastors from various backgrounds. The study used three different measures including: The Multifactor Leadership Questionnaire, Spiritual Transcendence Scale (STS) and NEO-fie factor Inventory (FFI) to measure leadership styles, spiritualty, and personality of 93 pastors (Carter, 2009). The purpose of this study was to ultimately evaluate pastors' leadership style, spirituality, and personality to determine if the variables were associated with the

effectiveness of pastoral leaders' (Carter, 2009). This information would be beneficial to understand the leadership styles of the pastors and to observe their rating for transformational leadership style. Those leaders' that showed positive correlation of transformational leadership style would be able to work best to develop trust from parishioners to be motivators and inspire the congregation to meet personal goals on various levels, whether it be spiritually of physically. Interestingly, the results indicated that the transformational leadership style displayed significant correlation with the effectiveness of pastoral leaders', which means these leaders could provide creative solutions to parishioners and attend to their individual needs positivity (Carter, 2009). Generally, leaders' in the study who exhibited transformational leadership are considered effective in encouraging various trainings (Carter, 2009), which may be beneficial as it relates to health promotion programing for the congregation.

After an extensive search of transformational studies between the years 2007 and 2017, there were over 20 existing articles. Of the articles explored, the studies that were mentioned in this section related to, related to transformational leadership theory, however none discussed how the theory could be used towards providing health-related information to congregations through health counseling. Conversley, the articles presented referenced the relevance of transformational leadership as an effective paradigm for faith leaders, and its enduring effect on parishioners.

Research Related to Content and Methodology

This section has information on the research related to both containing content and methodology. It also includes current literature on faith leaders insights on resources and training needed for them to be effective in providing health counseling to parishioners. The literature is limited pertaining to this specific topic. Therefore, the lack of studies available shows the need to investigate faith leaders experiences in this dissertation study.

Current Literature on Faith Leaders' Insights on Health and Wellness

Understanding faith leaders insights on health and wellness is useful when they are approached by parishioners to provide health counseling or to give health advice on various health-related topics. Fallon et al. (2013) used a national, cross-sectional, opt-in, internet-based approach to study faith leaders from small and large congregations to assess factors influencing them to provide faith-based health counseling to parishioners. There were 676 faith leaders that participated in this study where three items assessed their attitudes towards health counseling, by measuring health-related attitudes, and questions on self-efficacy for counseling (Fallon et al., 2013). Understanding these measures for the study gave a robust view of the factors that could hinder faith leaders from providing effective health counseling to parishioners. This study was successful in revealing that faith leaders with less likely formal education in smaller congregations were less like to provide health counseling to parishioners; on the other hand, faith leaders in larger churches faith leaders in larger church congregations were more likely to engage in health counseling (Fallon et al., 2013). This study also revealed the size of the

congregation was a meaningful factor to the faith leaders engaging in health counseling. Faith leaders expressed having a low level of comfort in speaking about health to parishioners, and Fallon suggest efforts should be aimed at increasing faith leaders comfort level in speaking with confidence to parishioners in order to change their health behaviors, as a result of health counseling.

Catanzaro et al. (2007) conducted a quantitative national study to compare insights of pastors' who had congregational health ministries, compared to those without organized health ministries, with a sample of 349 pastors representing over 80 denominations. Although this study focused pastors' insights regarding different types of health promotion activities, it failed to provide their views on providing health counseling to parishioners. The results indicated both pastors with or without health ministries still reported having some form of health-related activities in their congregations, however those with organized health ministries reported higher frequencies of health promotion and disease prevention activities (Catanzaro et al., 2007). These findings show that pastors that have organized health ministries and more likely to provide health promotion and disease prevention education to parishioners, because of formal planned health programs. The authors also cited that pastors reported the reason for non-involvement in providing health-related information to parishioners, was related to inadequate resources, which included the need for financial resources (Catanzaro et al., 2007). These results suggest the need for pastors to collaborate with health care institutions, nursing schools, or educational institutions in order to get them involved with potentially helping with funding and research efforts (Catanzaro et al., 2007). These researchers also emphasized

the need for public health nurses to be involved in working with health ministries, which lead to positive health outcomes among congregations served in the community (Catanzaro et al., 2007).

In a qualitative research study conducted by Ngamaba (2014), a phenomenological designed was used to capture faith leaders insights on their emotional and psychological needs and the impact on their congregation. Faith leaders play a key role in FBOs and it is important not only the parishioners needs are met, but the needs of the faith leaders as well, because they also have their own issues to deal with. Seven participants were involved in the study and received in-depth semi structured interviews to assess four clustered themes to help participants describe emotional and psychological problems they endure. It was reported that faith leaders in the study experienced challenging emotional statuses, such as feeling stressed or burdened, tiredness, anger, and sleep disorders (Ngamaba, 2014). The different health issues described in the study that faith leaders expressed, might contribute to a range of psychological difficulties among the leaders. Although faith leaders offer support to parishioners during formal counseling, Ngamaba highlights the hardships faith leaders have when they are personally affected by their own problems. The literature points to the fact that faith should collaborate with mental health professionals, psychologists, and health-care professionals to provide a support network to help themselves, along with parishioners (Headman 2014; Webb, Bopp, & Fallon 2013).

Webb conducted a qualitative study to explore faith leaders insights, attitudes, and involvement with FBOs by use of themes including: health and wellness promotion,

health, and spirituality. The study used a volunteer sample of 413 faith leaders represented from various denominations such as Methodists, Catholic, Lutheran, and the Church of Christ (Webb, Bopp, and Fallon, 2013). This study qualitatively examined faith leaders insights and linked them to themes that include health, which could be useful for the present study to know if faith leaders feel they have the adequate knowledge to counsel parishioners on health-related issues. Results from the study referenced some of the faith leaders "mentioned a lack of knowledge or expertise in health and wellness as a barrier to health promotion" (Webb, p. 240). This information reveals that perhaps faith leaders need training around health and wellness to offer health promotion to their congregation and if needed, provide health counseling to parishioners. The study also revealed that faith leaders want to know where to find resources that will allow them to talk about health to parishioners (Webb, Bopp, & Fallon, 2013). These resources could come from health professionals of various sectors or by reach out to institutions that provide public health research as this present study wishes to adhere.

Summary

There is currently more awareness on the importance of providing health-related information to FBOs, where faith leaders dictate buy-in and have the trust of the parishioners in delivering health information from the pulpit or even during one-on-one counseling (Campbell et al., 2007). Literature on FBOs and the role of faith leaders in providing health counseling, health-related information, and health promotion activities were acknowledged and complied in a logical fashion to understand the information needed for the present study. Considering the limited studies on this topic, recent

literature has helped to fill in the gap because it addressed faith leaders' insights in providing health counseling to parishioners, as well as what training or resources are needed to promote healthy outcomes among the congregation.

Throughout this chapter, I presented studies revealing that faith leaders have an influence on present health-related information given to parishioners to address their health concerns. However, the research indicated that faith leaders still need support from other entities and professionals to address health issues. The transformational leadership theory has features to employ the need for faith leaders to express leadership traits, which will be effective in delivering health counseling to parishioners. The next chapter contains methodology, where I discuss the research questions, research design and rationale, role of the research, details on the phenomenological approach, data analysis, issues of trustworthiness, and ethical procedures in research.

Chapter 3: Research Method

Introduction

The purpose of this qualitative phenomenological study was to understand the experiences of faith leaders providing health counseling to parishioners in an effort to improve the health of the congregation. In this chapter, I present the methodology and design related to the research questions. Information on defining my role as the researcher is expressed, along with specifics on how this study was conducted. Additionally, I illustrate how I ensured the trustworthiness of the data and how I addressed ethical considerations related with to this study.

Research Design and Rationale

Research Questions

The research questions explained in Chapter 1 are reprised below to support the design rationale of this study.

RQ1: How does motivating parishioners to achieve positive health outcomes influence faith leaders' role in health promotion?

RQ2: What are faith leaders' experiences as members of the clergy in providing effective health-related information to parishioners?

I also addressed the following subquestion:

RQ1a: What are faith leaders' insights of health-related issues affecting their congregation and the community?

Research Tradition

There are various approaches to conducting qualitative research, which has extensive traditions. There is an abundance of evidence that indicates faith leaders participate in providing health counseling to parishioners Fallon et al., (2013); however, little is known as to whether faith leaders consider the information given to be beneficial based on their knowledge about health. The lack of training and skills of faith leaders is important to consider in order to successfully improve health behaviors among parishioners. The purpose of this study was to identify the insights of faith leaders in an effort to improve the health of the congregation by seeking to understand what resources or training is needed for them to provide effective health counseling. In addition, transformational leadership theory was constructed to understand traits that may be exhibited by faith leaders to show motivation towards their followers in order to promote change in health behaviors.

In this qualitative study, I explored the faith leaders' experiences and insights in regards to providing effective health counseling to parishioners. I strived to identify and understand the factors needed to provide the necessary support for faith leaders who counsel parishioners on various health-related topics that may arise during counseling sessions. To my knowledge, there is little to no research that has gathered the insights of faith leaders in this capacity, which implies that this research is a fresh inquiry, where the goal was to understand a phenomenon. In addition, the versatility of the qualitative method allows faith leaders to fully describe their insights, resulting in new findings and knowledge to promote positive health outcomes (Ulin, Robinson, & Tolley, 2005). The

reason for choosing the qualitative research method for the present study is due to the need to receive participants views, in contrast to quantitative research, which focus on deductive logic to employ statistical and numerical data (Al-Busaidi, 2008). The deeper, personal views were the observations needed for the present research.

Phenomenology

As explained by Creswell (2013), phenomenology offers the influence of human experiences about a phenomenon that participants define. A phenomenon (used in phenomenological research) can be a feeling, relationship, or an entity such as a program, organization, or philosophy (Katsirikou & Lin, 2017). Phenomenological approaches help the researcher understand the lived experience of the participants involved in the study as participants discuss their personal practices. The research questions for my study addressed the phenomenon of interest concerning faith leaders' insights, as they related to receiving responses of their experiences on the topic, featuring a phenomenological approach (see Creswell, 2013).

According to Patton (2015), Philosopher Edmund Husserl was the first to use the philosophy of phenomenology and defined it as the study of how individuals describe things and experiences through their senses. Husserl also implied that the only way to understand an experience is to study insights and meaning within one's acquainted awareness (as cited in Patton, 2015). This simply means that a person cannot ponder on a lived experience while living through the experience. Ideally, the phenomenological indication must be retrospective (Creswell, 2013).

There are two main approaches to phenomenology derived by Husserl: transcendental phenomenology and hermeneutical phenomenology (as cited in Creswell, 2013). Transcendental phenomenology focuses less on the researcher's interpretations and more on how the participants describe their lived experiences. This concept also uses bracketing, where the research is set aside from individual experiences and places emphasis on the new understandings offered by the person who experienced the phenomenon (Creswell, 2013). On the other hand, hermeneutical phenomenology focuses on lived experiences along with the texts or hermeneutics of life (Creswell, 2013). In this study, I used the transcendental phenomenology approach to understand the insights and experiences of faith leaders' ability to provide health counseling to parishioners. Phenomenology was the best approach to address the study research questions and purpose.

Role of the Researcher

In most qualitative research, researchers commonly collect data or information captured in participant's natural setting and often employ face-to-face interactions with individuals (Creswell, 2013). As the researcher of this dissertation study, it was helpful to have over 15 years of professional experience with planning, implementing, facilitating, and evaluating public health programs. In previous positions as a health education specialist for my local health department in the rural area of Jones County, NC, I worked with various faith leaders within FBOs. The experience of working with faith leaders was beneficial to establish a rapport while conducting the interviews for this present study.

It has been rewarding to currently serve as a team leader of the health and wellness ministry at my church; however, I did not have a participatory role in this study. In my role, I was strictly to operate as the interviewer to eliminate any biases with the study participants.

Methodology

Participant Selection Logic

The target population for this study was faith leaders of various denominations and ethnicities in Northeastern NC. Convenience sampling was selected to find faith leaders who were easy to access from various FBOs and to gain knowledge that is representative of the sample drawn (see Etikan, Musa, & Alkassim, 2016). The logic of using convenience sampling was to interview faith leaders who represented diverse FBOs, such as churches, mosques, and synagogues in Northeastern NC. Also, the faith leaders within these FBOs needed to be established for at least 2 years. The inclusion criteria also specified that faith leaders needed to be representative of both male and females over the age 21. To ensure the quality of the research, these criteria were suggested to provide in-depth information about their lived experiences and to have participants ideally suited for the study, who were more willing to share their views (see Abrams, 2010; Sutton & Austin, 2015).

The sampling strategy was used to obtain a better understanding of the faith leaders' insights giving health counseling in relation to how, when, and why. In considering the research questions and the number of variables and themes, the sample size of 15 participants is appropriate for small samples of phenomenological studies (see

O'Reilly & Parker, 2012). Sampling is a major factor in data collection and is founded upon the research theme, goals, and inquires; it is vital to the veracity of the study, to acquire large amounts of data and to obtain saturation, which is associated with significant analysis (Abrams, 2010).

Instrumentation

To ensure interview questions were appropriate and in compliance with the Institutional Review Board (IRB) polices of Walden University, the interview questions included documentation items. Interview questions were reviewed by experts with prior experience working with faith communities and faith leaders. Emphasis was given to experts who have a dual role of faith leader and health professional. An email was sent to out to experts in the field to review the interview questions to achieve validity. The experts gave their insight on opinions on revisions that needed to be made, and I was able to revise the interview questions based on the feedback received. Next, a formal interview protocol was developed in order to confirm the validity and reliability of questions when conducting the interviews with faith leaders. According to Creswell (2013), an interview protocol is beneficial in providing the interviewer with a document where all the interview questions can be written in one place and is effective to use for qualitative inquiry. My intent was to use researcher-produced data collection tools, which Chenail (2011) highlighted as an appropriate method to learn more about the phenomenon of the study.

In this study, I used open-ended interviews questions that were auto-taped to understand faith leaders' insights on providing health counseling to their members to

promote health and wellness. The use of open-ended interviews questions provided the opportunity the participants to share their experiences in the own way (see Creswell, 2013). In addition, interviews are able to give researchers a better understanding of the phenomenon.

Procedures for Recruitment, Participation, and Data Collection

Recruitment

All the interviews were conducted at the participants' FBO or the specific room selected based on the availability at each location. The data collected during the visit of the interview happened on a weekly basis until all interviews were complete. The interview lasted approximately twenty minutes to one hour in length and a digital recorder was used. I recruited participants by reaching out to various established faith health groups, councils, social media, and gaining access from experts that currently work with some of the faith leaders. Other recruitment strategies were presented, such as emailing faith leaders and making direct telephone calls.

Participation

The goals of the research were communicated to potential participants and it was explained that the study was voluntary. The faith leaders that wished to participate in the study met the inclusion criteria, and was accepted as study participants to share their insights with me. Participants were ensured all information would be kept private and secure, and that they would be given the opportunity to review their transcript upon request.

Data Analysis Plan

Data analysis is an important concept to adhere to in qualitative research in order to interpret the data and report what was learned from participants. The rigorous analysis during the qualitative research process can introduce statements that illuminate the given voice of participants lived experiences (Raskind et al., 2019). Understanding the participants voices allowed me to transcribe the audio recorded interviews and include the experiences and insights of each participant in answering the research questions.

According to Kegler et al., (2019), identifying the major steps for phenomenological data analysis include: structuring the data from the research questions, reviewing the data, detailing specific themes of participants experiences, and interpreting the results. I began transcribing the verbal data by listening to each recorded interview multiple times before starting the coding process. Pre-coding was used by highlighting, bolding, and color coding to begin the process of identifying emerging themes and patterns (Saldaña, 2016). Each interview question was reviewed intensely by dissecting each line and phase of each question. From this process, I recognized specific emerging themes from the questions, and to categorized them before entering the data in NVivo. The use of NVivo computer software and digital recording for transcription as tools to manage data collected from the analysis was used to gather identified themes. Next, similar topics were clustered together to show the relationship between the codes (categories). To maintain confidentiality of participants, each faith leader was given a unique numeric identifier, while using the NVivo 12 qualitative coding software.

Issues of Trustworthiness

To confirm trustworthiness in qualitative research, researchers must build trust and rapport with their participants to foster rich, detailed responses (Cope, 2014). Also, qualitative researchers should allow adequate time to collect data and obtain an understanding of the individuals and phenomenon in qualitative studies (Cope, 2014). To sustain the quality, trustworthiness, and credibility of this study, there are different aspects to consider in effort to have effective results. It was important that the data from the interviews were transcribed accurately and were of high-quality. Reliability was a concept used to ensure quality, trustworthiness, and credibility during the interview process. Assessing the reliability allows researchers to make judgments about the 'soundness', in relation to the application and appropriateness of the methods undertaken and the certainty of the final conclusions (Noble & Smith, 2015). Dependability was considered, which allowed me the ability to change or repeat research techniques to receive consistent results. The use of reliability was helpful for me to enhance the notes from the interviews by employing good quality recording and transcribing the information (Creswell, 2013).

To ensure credibility and trustworthiness in qualitative research, the term reflexivity must be considered to avoid researcher bias in this study (Cope, 2014). Reflexivity can ensure quality of qualitative inquiry by helping researchers be attentive and aware of social, cultural, and political perspectives, while reflecting one's own voice to ensure trustworthiness and authenticity (Patton, 2015). To ensure transferability,

detailed records were kept, of all research activities including the data collection and analyses.

Ethical Procedures

The study caused no harm or risks to participants' and was conducted after approval from Walden IRB. I provided informed consent to each participant before the interview process began and explained the purpose of the study to each faith leaders. The participants were ensured that all information remained confidential and anonymous. Anonymity was confirmed by excluding and names from the study to eliminate any personal identifiers. The data was password protected and stored electronically, and adhered to university polices for the timeframe to remain on file.

Summary

This chapter provides details entailing the methodology of the study. This chapter included the research design and rationale, research tradition, role of the researcher, section of participant selection, data analyses, instrumentation, procedures for recruitment, participation, data collection, and the credibility of the study. Phenomenology was used to show descriptive information to receive the faith leaders experiences as members of clergy and to understand their views on health counseling. These methods of inquiry may lead to the research finding in Chapter 4, which include the results of the interviews conducted in order to address the research questions.

Chapter 4: Results

Introduction

The purpose of this research was to gain an understanding of faith leaders' experiences on their role in providing health counseling to parishioners to improve the health and wellness of the congregation. Understanding the experiences faith leaders have encountered during their time providing any form of health counseling to parishioners, helped to address the research objective and understand the resources needed. In this study, I addressed the following research questions: (a) How does motivating parishioners to achieve positive health outcomes influence faith leaders' role in health promotion, (b) what are faith leaders' experiences as members of the clergy in providing effective health-related information to parishioners, and the subquestion (c) what are faith leaders' insights of health-related issues affecting their congregation and the community?

I start Chapter 4 with a brief overview of the various locations and setting of the interviews, along with demographics of the participants and details of the process of data collection and data analysis. I also include a discussion of the themes derived from the data collection procedures, followed by evidence of trustworthiness. Next is a discussion of the findings for each of the research questions. I conclude the chapter with a discussion of discrepant cases and summary of the responses to the research questions.

Setting

The interviews with the faith leaders were conducted in a private setting in order to set a comfortable atmosphere while ensuring confidentiality of each participant. All

interviews were conducted face-to-face to gain informed consent from each participant who chose to voluntarily participate.

The seating arrangements were consistent, with the participants sitting directly across from me; at no time was the participant beside me. The majority of the interviews were held in the faith leader's office, followed by a conference room, public library, and in a local coffee shop offering private seating away from customers. Six interviews were conducted in the faith leader's private office, where we sat across the desk for each other. Five interviews were conducted in a church conference room, where there was seating around a table. Two interviews took place at a public library in a small meeting room. The remaining two interviews took place in a local coffee shop, which offered private seating in quiet area to conduct the interviews away from other customers.

Demographics

The interviewed faith leaders represented various denominations and FBOs in Northeastern NC. Fifteen faith leaders (10 men and five women) agreed to participate and were interviewed. The confidential details such as the faith leader's name, church name, denomination, contact information, and title were kept secured during the research process. The age of participants ranged from mid-40s to early 70s. Three were in their 40s, while the others were between 50 and 70 years old.

The location of the FBOs ranged from metropolitan to rural areas in Northeastern NC. There were various denominations and religions represented in the study, including Baptist, Catholic, Episcopal, Jewish, Muslim, Hindu, Buddhist, Jehovah Witness, Mennonite, and Non-Denominational. It was important to interview faith leaders from

several denominations and ethnicities because there is limited literatures that shows data from faith leaders from of different backgrounds. The faith leaders' titles included Imam, Rabbi, Bishop, Reverend, Pastor, Priest, and Apostle. The sizes of the congregation ranged from less than 50 to over 1,500 members. Table 1 displays specific details of demographics in the sample.

Table 1

Participant Demographics

Identifier	Role	Religious affiliation	Age (years)	Congregation size
Faith Leader 1	Rabbi	Judaism	60-70	<100
Faith Leader 2	Bishop	Freewill Baptist	60-70	>100
Faith Leader 3	Priest	Roman Catholic	60-70	<100
Faith Leader 4	Reverend	Missionary Baptist	50-60	>100
Faith Leader 5	Pastor	Southern Baptist	50-60	>100
Faith Leader 6	Pastor	Non-Denominational	50-60	>100
Faith Leader 7	Pastor	Episcopal	60-70	>100
Faith Leader 8	Iman	Islam/Muslim	40-50	>100
Faith Leader 9	Apostle	Non-Denominational	60-70	>100
Faith Leader 10	Chaplin/Pujari	Hinduism	50-60	>1000
Faith Leader 11	Spiritual Leader	Buddhism	70-80	>100
Faith Leader 12	Pastor	Jehovah Witness	70-80	>100
Faith Leader 13	Pastor	Mennonite	50-60	>100
Faith Leader 14	Bishop	Seventh-Day Adventist	40-50	>100
Faith Leader 15	Bishop	Mormonism	40-50	>100

Data Collection

The methods of beginning the data collection process were well thought out to examine researcher bias and to recruit faith leaders from various backgrounds and religions. After Walden IRB approval, all 15 faith leaders received email invitations, along with a follow-up phone call to schedule the interviews. The email invitation contained a brief description about the purpose of the study, expectations, and my contact information if they wanted volunteer and schedule the interview. The follow-up phone call allowed us to agree to a location, date, and time of the interview. During the

recruitment process, seven faith leaders did not respond to email invitations or phone calls and therefore did not participate in the research study.

Location, Frequency, and Duration of Data Collection

Once the 15 participants received a follow-up phone call and accepted the email invitation to participate in the study, the interview was scheduled at their desired location. Each participant was given the time frame of a 45 to 60-minute interview and was told about informed consent that would follow at the face-to-face interview. Five of the interviews took place in the organization conference room, six in the participant's personal office, two at the public library, and two at a local coffee shop. All of the interviews were in-person and began with informed consent and the option to receive a copy for their records. The approved Walden IRB number 08-29-18-0412232 was signed by each participant before the interview began, along with my signature before the recording started. After the informed consent was signed, I gave the participants the opportunity to ask any questions or concerns before starting the recording.

The duration of each interview ranged from 20 minutes to 60 minutes, depending on the in-depth details provided during each response. Each question was read with a scripted interview protocol to capture participants responses. The use of eight open-ended questions along with probes were part of the interview protocol (see Appendix A). Two of the interviews ended with an unexpected tour of the facility and history given about the organization. Although the tours were not planned, they were still in the time frame to complete the interview within the 60 minutes.

Audio Recording and Transcription

I used an Apple iPod digital voice memo application to record all the face-to-face interviews and saved them into folders on the device. The iPod worked efficiently, and there were no technical difficulties during the interviews. The device and voice memo applications were both password protected to ensure confidentiality of all the stored audio recordings collected on the iPod. At the end of each interview, the recording was stopped, and I thanked the participants for their time and asked if they had any additional questions. If there were no additional questions or concerns acknowledged, the interview was concluded and details on next steps with the study were presented. I also gave each participant reassurance that no personal identifiers would appear in the dissertation.

The interviews were transcribed verbatim by listening to the recording and typing the data in Microsoft Word (MS) Word. The data were then transcribed in MS Word, and each interview was saved into Google Drive to have a second secure place to store the transcriptions. The transcriptions were also saved on an encrypted password protected flash drive, and no names were associated with the recorded interviews. I also assigned a numeric encryption to each participant's transcribed interview to ensure their anonymity. As required by IRB, all hard copies and electronic data will be kept in a secure place and kept for 5 years, then discarded properly.

Data Analysis

The process of reporting the interpretation of the coding procedures needs to be well understood to render the results for the dissertation research. According to Clark and Vealé (2018), the role of the researcher is to thoroughly review the research for

specific codes and common themes and to disclose their own assumptions or biases. Therefore, prior to analyzing the data, I had to consider and tried to take away any assumptions, biases, beliefs, or perceptions about faith leaders' experiences in providing health counseling to their parishioners. Bracketing allowed me to set aside any known biases to accept new ideas that the research could offer and to approach the topic with a fresh view before coding the research (see Brigitte, 2018). Because I bracketed my experiences prior to analyzing the data, I had the opportunity to focus on listening to each interview respectfully and engaging in the dialogue to enhance what would come from the research findings. The use of bracketing gave me the opportunity to demonstrate validity during the data analysis process in order to address the phenomenology study and have a concreate explanation to elicit strategies during the research planning (Chan, Fung, & Chien, 2013).

Once the recorded interviews were transcribed in MS Word, each transcript was read thoroughly, multiple times to check for errors in an effort to begin understanding the insights of each participant. The use of MS Word allowed me to begin by manually coding the data and highlighting certain sections of the text to guide the process before deciding to use a qualitative software program (see Belotto, 2018). There was a timeframe where transcriptions were reviewed over again in order to interpret the research from different angles and to capture new concepts that may not have been seen in the first coding of the data. Rettke, Pretto, Spichiger, Frei, and Spirig, (2018) explained that this method is called rapid reading and is a vital process to give the reader

an innovative approach to the research after the transcripts are read multiple times in their entirety to gain new ideas.

Next, each transcript was uploaded into QSR International NVivo 12 Pro to perform software-assisted qualitative research by storing, managing, setting queries, and organizing the raw data entered in the program (Guo, 2019). NVvio was helpful in giving a platform to code and sort data to create nodes, which allowed for emerging themes or patterns to be developed. The program helped utilized queries to learn what words were frequently used and to create a word cloud. A word cloud is a technique used in NVvio to visually view regularly used words, after a word frequency query is processed (Guo, 2019). The two words that were reviewed the most in the word cloud interpretation was parishioners and health.

The total of five themes and twenty-one codes were identified after data was accessed in NVivo. The five themes formed were motivating parishioners to improve health, faith leader seen as a resource person, faith leader support, health status of parishioners, and separation between physical health and spirituality.

The interviews with the faith leaders consisted of eight questions (Appendix B). The interview questions were designed to answer the research questions and relate back to the transformational leadership theory. Of the eight questions, six were used directly to answer the three research questions. Question 5 was designed to received faith leaders insight on their role and influence in providing health promotion to parishioners through their teaching, along with sermons. A follow up question 5A was also provided to gain faith leaders thoughts if they could motivate parishioners through their teachings and

sermons given. Leading to Question 7, which also addressed how faith leaders could motivate parishioners, if given the necessary health resources. The three questions were directed towards the first research question and the transformational leadership theory, which focused on motivating parishioners to achieve their desired goals, which could be health-related. Question 1 assisted in answering the second research question by giving faith leaders a platform to describe their role in providing health counseling, and by understanding how they thought parishioners viewed that role. Questions 2, 3, and 4 were able to address research question 2, understanding the faith leaders experiences in providing medical advice to parishioners and learning what they could actually provide.

Questions 6 and 6A was able to answer subquestion RQ1a. of the research questions, allowing faith leaders to express health challenges and conditions facing parishioners, along with providing their thoughts of the factors contributing to the health conditions. Question 4 was designed to obtain the faith leaders experiences and better understand the necessary training and skills they thought were needed to provide support to parishioners during a health counseling. Lastly, questions 8, 8A, and 8B aided in receiving feedback from faith leaders in order to discover if they had a health promotion ministry, and what health and wellness programs or activities where happening in their congregation or community.

Discrepant Cases

While most of the faith leaders found it important to incorporate health information into their teachings and sermons if given health resources, there were two that did not agree. Faith leader 14 felt that if health resources were provided, they did not

want this information to “shape their sermons”. This faith leader later explained that incorporating health information during a sermon, would be too much, however the information could be offered on paper, but not to be given to parishioners from the pulpit. Faith leader 13 thought there was no need to give health information during the teachings, because parishioners should “trust in God and He will take care of us”. This same faith leader had a different response when asked about the health conditions affecting parishioners. They felt that everyone was healthy because the “congregation was fairly young”. Overall, the contradictory responses display the need to understand what resources and health information are essential for faith leaders to provide to parishioners.

Evidence of Trustworthiness

The research study focuses on a valuable topic, to gain insight of faith leaders experiences in providing health counseling to parishioners in an effort to learn the resources they need to do the work for their congregation and community. Consistency was achieved to provide a comprehensive and balanced representation of the findings in the research (Korstjens & Moser, 2018). Trustworthiness or rigor is an important concept to consider in understanding the value or veracity of qualitative research in order to provide useful finding and interpret the results (Connelly, 2017). This research will outline criteria that will focus on credibility, transferability, dependability, and confirmability to ensure the finding can be trusted (Korstjens & Moser, 2018). The rich details throughout the study provides the participants reflections through the transcribed interviews. Under the Walden IRB approval, there were specific methods identified to

ensure there were not ethical concerns and that each participant would be respected, without causing harm. This study demonstrated methods that showed detailed notes were generated and standards of quality were exemplified in the qualitative research (Connelly, 2017).

Credibility

To be compliant and have a credible research study, the data collected from the faith leaders was interpreted verbatim, detailing their experiences that were relevant to the interview questions. The information drawn from the participants presented finding that had plausible details from original data to collect accurate interpretation of their experiences (Korstjens & Moser, 2018). Ensuring credibility was important, therefore the researcher used bracketing to review and reveal all predispositions by examining the research data without bias. The researcher also made sure that participants understood the interview questions once read, taking into consideration, all possible levels of literacy. Literacy was also considered due to the age of many of the participants, and it was important to consider credibility strategies. Triangulation was documented by use of multiple data resources to gain insight from different faith leaders, having multiple religions represented (Korstjens & Moser, 2018).

Transferability

I captured transferability by receiving the faith leaders shared experiences. In addition, using storytelling as a depiction helped the reader visualize detailed descriptions of the data collected. I then carefully kept detailed records of all the research, emerging themes, processes, and analyses collected this information. Korstjens and Moser (2018)

strategy “thick description”, can be used once data is collected to describe the participants and the research methods, so it becomes meaningful to the reader. The use of the interview protocol ensured all participants were asked the same questions with rich detailed information to support the research.

Dependability

The research process and steps taken to achieve consistent findings was strategically planned to ensure dependability. Transparency was demonstrated when describing the steps provided to conduct the research approved by Walden IRB (Korstjens & Moser, 2018).

An effort was made to confirm all interpretations and recommendations were supported by the data received from each participant (Christenbery, 2017). Obtaining the correct number of participants was thoroughly planned and accomplished to reach the study goals and receive different views on faith leaders experiences. Evaluating the findings to support the data during the coding process was achieved by gaining a deeper knowledge of the patterns and themes determined (Christenbery, 2017).

Confirmability

NVivo was used to store detailed transcriptions and notes collected with specific coding markers to evaluate the findings by capturing viewpoints and evaluating the data. Confirming the results of the study was derived from the data and was essential in summarizing the findings of the research (Christenbery, 2017). The results of the study ensured the quoted responses were supported by the analysis rendered (Connelly, 2017). All detailed responses, which includes audio recordings of each interview, notes, and

written transcripts collected during analyzing data, will be saved for a minimum of five years as required by Walden University and accessible upon request.

Results

The purpose of this study was to gain an understanding of faith leaders experiences on their role in providing health counseling to parishioners, to improve the health and wellness of the congregation. The intent of the research was to clearly understand faith leaders experiences and abilities to provide health information to parishioners, along with learning the resources needed. To understand this phenomenon, the following two research questions and one subquestion were identified. Research Question 1: How does motivating parishioners to achieve positive health outcomes, influence faith leaders' role in health promotion. Research Question 2: What are faith leaders' experiences as members of the clergy in providing effective health-related information to parishioners? Subquestion: What are faith leaders' insights of health-related issues affecting their congregation and the community?

A comprehensive literature review and theoretical framework of the transformational theory helped in the development of the research questions. The interview protocol helped me recognize and understand the lived experiences of the faith leaders through their insights on providing health counseling to parishioners. It was evident that parishioners confided in faith leaders and made them aware of their health conditions and concerns (Fallon et al., 2013). The probes and flexibility with the delivery of all questions ensured the details and information identified themes, codes, and patterns to reach data saturation (Saunders et al., 2018). The transcripts were read thoroughly and

reviewed multiple times to hear the participants experiences to meet the research goals and support the findings. I also examined the interview responses to sorting them under the correct research question, as themes were determined. Two themes were developed because of the data analysis, in the next section, in order to gain an understanding of Research Question 1.

Theme 1: Motivating Parishioners to Improve Health

The first research question was given to all 15 faith leaders to understand how motivating parishioners to achieve positive health outcomes was part of their role. This research question also addressed the transformational leadership theory where motivation is a characteristic that influences faith leaders to inspire change, which could occur in their congregation. Transformational leaders are able to empower and enable change within an organization, which could happen if faith leaders are able to provide health resources to parishioners (Ghasabeh, Reaiche, & Soosay, 2015). All responses related to this theme involved the faith leaders role in motivating parishioners. To ensure confidentiality, I labeled the participants as FL1 through FL15.

FL1 stated, “From a faith perspective, the parishioners have given me permission to challenge them. I can bring in spiritual resources, to say when you hurt yourself your hurting all of us.”

FL2**.** “Setting the example as a faith leader. I have lost weight myself and have push them to exercise. I go to planet fitness.”

FL3. “Educating them and talking about health to them.”

FL4. “It’s done by bible principles that are taught; example Proverbs talks about having a clean heart...We encourage our members through bible verses, such as getting upset could damage their body”

“We motivate them through the scriptures...”

FL5. **“**Not so much teaching it across the pulpit, however, would like to be in a setting that they can ask questions and get answers. I do believe that when you get a person to understand, they can help themselves more. It takes more time for the elderly to take change...”

FL6. **“**Members can be motivated if you highlight certain health topics and increase awareness.”

FL7. **“**People can have a transformation from the teachings.”

FL8. **“**The best way would be fasting, and then doing the 21 day fast. The fast motivated and encouraged them to eat better and not eat meat, along with sweets. They thought it was spiritual, but really was a physical aspect. Parishioners do need motivation; it was easier to motivate the women verses the men.”

FL9. **“**Examples plays a part in motivating parishioners, not only preaching and teaching of the church leaders. It is also the examples that we are setting as faith leaders.”

FL10. **“**Connecting and knowing where the resources are and helping faith leaders to find the support is important to help parishioners make better choices.”

FL11. **“**Motivating them to eat better should be a lifestyle change instead of dieting.”

FL12**. "**I will give them incentive, make it fun, and providing them the tools they need.

FL13. **"**We can show them how different foods can be made in healthier ways."

FL14. **"**Setting by example…"

FL15. "Have structured time that people should disengage and pull away from things (called the Sabbath). It traditionally happens for 25 hours. This something I encourage them to do even if it only for 5 minutes."

Theme 2: Faith Leaders Seen as a Resource Person

This theme was generated to also answer the first research question and find out from faith leaders how parishioners viewed their role in providing health-related resources.

FL1 stated **"**To give them information, and to share my experiences."

FL2. For Example "A member ask if they should have a kidney removed and if I though it should happen. I told her I don't have a medical degree to tell you what to do, it's your decision."

FL3. **"**They seek health advice from their doctor or physician. I don't get questions much."

FL4. "We have 6 study groups, people know who to come to if they have questions or problems. They know to go to the Group of Elders, and the information we give them is for their benefit."

FL5. **"**They come to me freely and are very comfortable. I can contact people if I don't have the answer."

FL6. For example, “If they have cancer or family crisis, they come up and talk to me. They see me as someone to giving spiritual insight and it overlaps a lot with the physical and emotional.”…..I make many referrals..

FL7. Not sure if the members understand my role, but they need it . I think it’s my duty to provide the role of a health counselor……There are some people that believe in healing, and I go pray for them. They call me back and sometimes tell me the results.”

FL8. **“**People come here with issues, however we do not provide health counseling but the door is open to all people.”

FL9. “Word of mouth, if I know someone who has a situation, but unwilling to go to the doctor maybe an intervention is needed.”

FL10. For example, “Someone needing dental care, we took them to get dental care for free at a clinic. We are able to give them resources.”

FL11. For example, “There was a person whose husband had pass away and she was able to come to me, so I could provide her with counseling to help her get out of depression.”

FL12 “As a resource, and connecting the dots and connecting them to resources that they may need. Clergy are able to have face-to-face time with members and the community even more that their doctor, psychiatrist or someone in a professional building. We have more of an idea of what's going on in the community and the church can bring in the resources.”

FL13. **“**They see me as their spiritual leader and to help them if they have a conflict. Faith communities are not always good with modeling what it is like to be a fully functioning body.”

FL14. **“**They see me as being comfortable to come to.”

FL15. **“**I have a role by providing health programs such as Noah’s Skills Healthy Living Alliance….it starts with teaching the pastor's how to eat right then bringing that information to members.”

Theme 3: Faith Leader Support

This theme was derived to answer the second research question, to learn what support faith leaders need when asked by parishioners to provide health information or advice.

FL1 stated **“**The Pastoral Services at Vidant should provide more workshops to have trainings for faith leaders. If there could be mini workshops to have ongoing information to give clergy more training.”

FL2. **“**Seminars at the hospital…Events and seminars that are sometimes offered to clergy are sometimes not well attended. Maybe they don’t know about the events our the marketing is not good. I went to one that was low in attendance. They need to know how to find the resources to receive trainings.”

FL3. **“**Emergency response training…Have members that are doctors and nurses.”

FL4. **“**No specific training, we have a “Stop the Bleed Kit”, we have people that are EMT nurses, We don’t get specific training to provide health counseling to members.”

FL5. **“**I have people in my congregation that are in the medical field. I try to provide workshops “because knowledge is the key. Workshops are needed in the faith-based community and they could be given materials to take home. Some people don’t understand the seriousness of their health condition. For example, there is no need for you to be taking blood pressure medicine then going to eat a barbeque sandwich frequently. How to read labels can be very confusing to people...being informed and being taught knowledge...I want the people to be empowered after attending workshops.”

FL6. **“**Most seminaries today require CPE training, but was not around many years ago. (hadn’t heard of it 20 years ago). There is a gap in seminaries and the issue of providing more training has been recognized and is now being addressed ...to have some clinical practices offered. We are responding to people, especially in these informal settings, so training is really needed. There can be counseling moments that can happen informally, almost like a teachable moment.”

FL7. **“**We need education on counseling, and I think every pastor should get CPEs. The experience gives me the ability to ask the right questions when in the hospital room with members.”

FL8. **“**They need to read and study….or receive a degree...however they will need more than book training...to know more about how to provide health counseling.”

FL9. **“**Provide training where clergy can be health ambassadors.”

FL10. **“**They need to know Yogi, which is a person who practices yoga. The need to know mental, physical, and spiritual aspects.”

FL11. **“**We need to be well informed to know what is available in the community. We need to be interconnected to know where to direct people to give them the help they need.”

FL12 **“**Trainings that deal with mental, emotional, and psychological..”

FL13. **“**The main thing needed is a personal faith in G-d and know He is able to take care of our needs.”

FL14. **“**Education is important and learning more...Clergy don’t know the new skills, we did not go to school for CPR or mental health. We know more about the bible and the new and old testament. We need more training, our job is more than just being a clergy, but need to able to find resources to parishioners.”

FL15. **“**Basic first aid and CPR is needed. I can go to medical doctors to ask questions. I would help them set appointments for them to find a specific doctor which has been done before.”

Theme 4: Health Status of Parishioners

Understanding faith leaders experiences with various types of health conditions affecting their congregation or FBO, was an important aspect to receive from all 15 participants. This information will be helpful to recognize what types of health challenges their congregation have, to present them with assistance. The faith leaders had similar concerns and most identified the same health-related issues that other leaders deemed to be affecting their congregation. The subquestion was directed for faith leaders to list the common health-related issues affecting parishioners and are included below:

FL1 stated **“**Stress”

FL2. **“**High Blood Pressure, high cholesterol, and diabetes…”

FL3. **“**Cancer, diabetes, and general health concerns…”

FL4. **“**Arthritis and heart disease”…

FL5. **“**High blood pressure, diabetes, lupus, and Gout…”

FL6. **“**Diabetes and mental health issues”

FL7. **“**To satisfy their own desires…people want something…”

FL8. “Diabetes, high blood pressure, and heart disease…”

FL9. “Anxiety”

FL10. “Hypertension, diabetes, and mental health struggles…example would be depression.”

FL11. **“**Cancer and heart disease…”

FL12. “Diabetes”

FL13. “Diabetes, high blood pressure, and cholesterol…”

FL14. “Diabetes, high blood pressure, and cholesterol…”

FL15. “Diabetes”

Theme 5: Separation Between Physical Health and Spiritual

During the interviews, many faith leaders brought physical health perceptions to my attention; however, they also mentioned the spiritual side of helping parishioners through biblical teaching in order to lead their congregation to good health. The faith leaders discussed providing health information through their own sermons or teaching can be influential to parishioners health by relating it back to spiritual meanings.

FL1 stated **"**Yes, absolutely….body, mind, and spirit is apart of the teaching that could inform parishioners. If we are not healthy in spirit then it leads us to do unhealthy behaviors, which leads our health to be bad. Believe in a holistic understanding that we are made in God's image. What a preacher says is critical to people's health."

FL2. "Powerful and major issues especially in the African American community. Many don't know the importance of getting screened."

FL3. "We believe the body is a gift of God, and we need to take care of that gift. We encourage them to have good physical health. Rather than having a check-up or exercise program, or going to the doctor, it's an important part of them taking care of their body. They have a Health Code on the "The Words of Wisdom", not drinking, doing drugs…."

FL4. **"**It goes back to bible principles, we have public discourse. The public discourse teaching can talk about physical aspects and morals. It is effective in hearing the teachings."

FL5. **"**I agree, and do it through my teachings often. I encourage people to move do something, just continue to keep moving. I believe that members will receive information quicker from us as their Pastor/Shepherd than they would from someone else talking. The bible has information on food you can eat such as herbs….you can incorporate health in your sermon so it can still be beneficial and effective."

FL6. "I try to help people recognize the need to calm down and slow down, to not be so busy. This is what I preach in my sermons. I give sermons about the right amount of problems solving, with the goal being to get people to calm down."

FL7. **“**I became a vegetarian because of sermon. Sermons are a teachable moment; and one time I spoke about the benefits of sleep or making resolutions. Some of the resolutions are in the health area. Then survey the room and see a show of hands, and at the end of teaching more people raise their hands to make resolutions.”

FL8. “We are not there yet. we don't have many resources. Yes, the teachings are offered in English and Chinese and do have an influence. We give methods to help them think...

FL9. “It carries a lot of weight when you are able to talk about from the pulpit. You need to practice what you preach, as a faith leader...you need to look healthy yourself. I can't be the person eating oxtails or unhealthy food then telling the congregation to eat healthy.”

FL10. “All integrated into one and you cannot separate one from the other...you have to help parishioners mentally, physically and spiritually.”

FL11. “It is a tremendous potential. In my experience, most members that are in a crisis first go to their clergy to discuss what they are going through. Biblical preaching/ teachings can help people act right and think right. Your body is a temple, biblical teaching informs about your body and you have been bought with a price.”

FL12 “Yes, however don't think I would devote a sermon to only talk about high blood pressure and diabetes. Faith leaders do have influence because people look to their pastor;however, bring in opportunities that really help parishioners. Have parish nurses come and speak to parishioners, it could be a good program.”

FL13. “I preach that we need to trust in Him, if He wants us to be health...or using the medical system….He will take care of us.”

FL14. “You have to incorporate incentives to parishioners. If clergy work with their members and provide challenges to help them lose weight. For example, we had a challenge between other churches to see which district would lose the most weight. Not just tell them what to eat...we need to provide healthly foods to members.”

FL15**.** “I think it's very important and we should stress eating healthy and exercising. Even if it just walking... It can and has been done with our parishioners.”

Discrepant Cases

All faith leaders agreed that they could use training to promote health behaviors to parishioners, when they seek medical advice from them. There was consistency among faith leader mentioning the local hospital in their area offering Clinical Pastoral Education (CPE) training that could be useful when providing counseling to parishioners. One faith leader mentioned that it is great how the classes are offered, but they can sometime be low in attendance, and wondered if they could do a better job advertising the trainings. FL2 thought there should be more trainings offered in seminary, because he does not remember receiving the education on how to counsel parishioners, if they came to him about health concerns.

FL13 had opposing views and did not think it was necessary to have a health promotion ministry and said “God will take care of our needs.” This same faith leader did not think many of the members suffered from health conditions, because the majority of the congregation younger people. Also, almost every leader thought they did not have

the ability to provide health counseling, however the subject came up during counseling sessions and they were pressured to give an answer to help parishioners. One faith leader mentioned, “my advice is to tell them to do what the doctor says.”

Summary

Research Question 1: How does motivating parishioners to achieve positive health outcomes, influence faith leaders’ role in health promotion? The study participants’ responses indicated that they play a major role in motivating parishioners to achieve positive health outcomes, because members come to them for health advice. Faith leaders revealed parishioners feel comfortable coming to them about many health concerns, especially if they are having a surgery or major medical decisions that need to be made. It was expressed that parishioners are motivated most of the time by the faith leader giving them biblical information from their teaching and relating it back to the importance of them practicing positive health behaviors. They were quick to acknowledge the importance their personal beliefs and recognized the teachings, along with quoting different scriptures or mentioning principals that related back to ways that motivated parishioners. Many of the faith leaders mentioned they must be an example first, because parishioners are watching them, “therefore they need to practice what they preached”. Although, there is some indication that faith leaders can motivate positive health outcomes, they all mentioned there are many areas where improvement is vital.

Research Question 2: What are faith leaders’ experiences as members of the clergy in providing effective health-related information to parishioners? The responses indicated that all the faith leaders did not feel they had the ability to provide health-

related information or health counseling to parishioners. Many acknowledged there is a need to learn more because they do not have the qualifications to provide efficient health information to parishioners, when asked at counseling sessions. They welcomed outside resources if they were willing to come into their FBOs and offer health resources to parishioners. Eight of these faith leaders have health promotion ministries and provide wellness activities to parishioners. Out of the eight, many mentioned the need for that for financial support to continue providing health information to the congregation.

Subquestion: What are faith leaders' insights of health-related issues affecting their congregation and the community? Faith leaders were able to quickly and without much hesitation, give the health conditions and issues affecting parishioners in their organization. Some of the faith leaders were saddened and wished they could do more to prevent the health issues that many parishioners faced and that they are informed. It was interesting that many of the faith leaders stated the same health challenges, the top three included: high blood pressure, diabetes, and cholesterol. Understanding these health conditions affecting parishioners will give health institutions, community agencies, and partners who target the health of faith communities, the opportunity to expend their efforts.

In this chapter, I provided a brief analysis of the purpose, research setting, participants' demographics, data collection, data analyses, discrepant cases, evidence of trustworthiness, study results, including answers to the research questions. In the final chapter, I will summarize the findings of the study, describe limitations, provide recommendations, explain the impact of social change, and present the conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this phenomenological qualitative study was to gain an understanding of faith leaders' experiences in their role of providing health counseling to parishioners to improve the health and wellness of the congregation. The nature of the study allowed me to gather data in the faith leaders' natural setting in order to understand faith leaders' views and experiences based on the phenomenon addressed. I conducted this study to examine the barriers and resources needed to reduce health disparities and promote positive health outcomes in the congregation and community by interviewing faith leaders. In this qualitative study, I used a phenomenological approach to obtain information about faith leaders' experiences and insights about offering health counseling or health-related information to parishioners. Semi-structured interviews were used to prompt the responses from faith leaders, which allowed me to analyze themes and answer the research questions. The study revealed that faith leaders do not feel they can conduct health counseling, and information is needed to guide parishioners to resources in the community.

Interpretation of the Findings

Fallon et al. (2013) indicated that faith leaders reported that their own health status played a role in offering health counseling to parishioners in order to give health advice to others. The faith leaders interviewed in this study continued to mention their own self-image throughout, and the word "example" came up several times. FL13 leader

stated, “I am the first example; I don't believe in teaching people about their health and I’m not doing it.” FL2 also stated,

> We need to model how we want people to be. Therefore, cannot be the one being anxious or over engaged and pursuing for things. Then, I‘m showing the opposite of what the parishioners need to be doing.

Both quotes from the two-faith leaders support Bopp’s (2012) literature, as it relates to faith leaders playing a role in their own health before advising others. However, in contrast, they feel confident in wanting to improve the health behaviors of parishioners even if it means doing more to improve their health.

Fallon et al. (2013) also indicated that the best way for faith leaders to have effective health counseling is to provide them with training programs. In this study, I examined faith leaders’ experiences and received responses firsthand to discover what training and skills are needed to support them in offering health counseling to parishioners. The study participants did respond that more workshops need to be provided to give them ongoing information that would prepare them to give advice or offer resources to parishioners. Many discussed the need for CPE trainings to be offered in various locations to keep them up-to-date on faith-based initiatives and programs. Those who responded to receiving the training discussed that the attendance was low, and questioned if the organizations offering the trainings are truly reaching faith leaders who need the training. The literature is correct in referring to the need for additional training programs to be offered to faith leaders, but it is important that know how critical it for them to attend and bring the information back to parishioners.

The need for seminaries to offer trainings was a topic of discussion mentioned in the interviews by faith leaders, as they thought this would be an ideal place for them to begin receiving the information. FL6 mentioned that he could not remember receiving training in the area of health and thought it would be a great idea for those newly finishing theological degrees. Bopp et al. (2014) indicated a lack of support from seminaries to provide formal training on health-related issues affecting denominations and by not having enough resources to offer the training, although there is a desired need. This lack of infrastructure among seminaries proves the need for more trainings to be offered on the local level to support faith leaders who are often asked to give health advice and are not properly trained. Headman (2014) discussed how there is a growing concern among clergy, and there is not a set standard code of ethics guiding counseling practices. Hedman also detailed how clergy expressed the need to build communication with mental health professionals in order to help their congregations, who may have mental health struggles. This helps explain the responses from faith leaders who stated that it is important to be able to connect parishioners to mental health resources, but often it is difficult to know where to find parishioners the help needed.

Throughout the research transcripts, nearly all the faith leaders continued to use the words *confide*, *comfortable*, and *come to me* as their way of explaining how parishioners trusted them and could seek them out for all forms of advice, including asking them about major health decisions. Jo et al., (2010) confirmed that when interviewing 58 faith leaders, the parishioner would confide in and disclose his or her illness before seeking medical care. This research was critical in proving the need for my

research and understanding that there is more work needed to support faith leaders and the work they do for parishioners and the community. This research also reveals that many parishioners and those in their community would go to the FBO for financial help for health-related issues before going to a medical institution. This prior research confirms the response of FL1 and FL3, that many of the parishioners seek their financial help to cover medications or medical procedures. FL8 gave reference to having to take a parishioner to the hospital when they came to church and was not acting right, and the person had had a stroke. The individual was just trying to make it to the church instead of calling 911 for the emergency, and instead had wanted to ask the faith leader if they should go to the hospital.

There was an interview question that addressed whether faith leaders' had health promotion ministries provided to their congregation. Out of the 15 faith leaders interviewed, only eight had functioning health promotion ministries and offered health and wellness activities. The faith leaders who had health promotion ministries were eager to discuss the health and wellness activities they offered parishioners and the community. In one case, I was given a tour of a separate room at the church that had been dedicated to promoting health and wellness. The same church also offered a blood pressure screening station upon entering the sanctuary. Although the eight FBOs had health promotion ministries, the faith leaders still mentioned that their church had various health challenges. Baruth et al. (2015) highlighted that faith-based organizations are considered the ideal place to bring large audiences together at one time, which can increase health promotion efforts. In this study, I confirmed the need for health

promotion ministries; however, half of the faith leaders mentioned the need for financial support to be provided in order to carry out their health and wellness activities.

Theoretical Framework

The theoretical framework, transformational leadership theory supported the efforts for data analysis and interpretation of findings for this qualitative research study. Transformational leadership theory was selected to focus on the relationship between faith leaders motivating parishioners to promote positive health behaviors. This study examines the need for faith leaders to engage their followers' needs, while encouraging them with an inclusive level of motivation to reach their fullest potential (Northhouse, 2018). There are four leadership factors of transformational leaders: idealized or charismatic leadership, inspiration or inspirational motivation, intellectual stimulation, and individualized consideration (Northhouse, 2018).

Faith leaders reported how motivated parishioners were to improve their health through their teaching and sermons. It has been beneficial. All of the faith leaders gave insight about ways parishioners can be motivated directly through their teachings and sermons. FL4 responded, "It's done by bible principles that are taught. For example, Proverbs talks about having a clean heart...We encourage our members through bible verses, such as getting upset, could damage their body…We motivate them through the scriptures..." This statement holds true to the transformational leadership theory second factor, inspiration or inspirational motivation, referring to leaders who are descriptive in communicating high expectations to followers. This can inspire parishioner to make better health choices. The encouragement from their leader, such as the faith leader

having pep talks and using inspiring words describe how the second factor is expressed in the research.

Nahavandi (2014) identified that transformational leadership is a theory that should be used to encourage followers to evoke innovative change. Faith leaders hold leadership qualities, due to the nature of them leading a FBOs and having followers that trust in them. The first factor idealized or charismatic leadership, where leaders' act as robust role models for followers, is exhibited by parishioners (Northhouse, 2018). This is due to the fact that leaders of faith are respected by parishioners and many develop a great deal of trust in them. Sosik, Chun, Blair, and Fitzgerald, (2013), study results indicated that self-assurance concepts that motivated faith leaders was reflected highly in the transformational leadership. This is beneficial for faith leaders to build a strong relationship with followers to motivate them to adapt positive health behaviors through the leaders sermons. FL2 responded, "If I had the opportunity to give health resources to members I think it would be helpful in motivating them. I would welcome the opportunity to help the people."

Limitations of the Study

The first limitation of the study was the desire to have more FBOs and religions represented in the sample. Although, fifteen interviews were conducted, not all were from different religions/denominations. There were Baptist (3), Catholic, Episcopal, Judaism, Muslim, Hinduism, Buddhism, Jehovah Witness, Mennonite, Adventist, Mormonism, and (2) nondenominational (2). Based on the demographics of religions in Northeastern NC, it was difficult to find multiple faiths represented, without driving

distances of over 200 miles. Southern Baptist is the predominate religion in the study area, however it was still an accomplishment to receive a diverse range of religions represented for the study (Vines, Hunter, White, & Richmond, 2016). This finding is evident as to why the Baptist were represented the most in the sample.

Another limitation was the lack of women participants to be represented in the study. There was a total of five female faith leaders, compared to ten male faith leaders in the sample size. Although, there was a small number of women in the study, inclusion of them sharing their insight gave a different voice to ensure integrity in the research study (Winters et al., 2018). This could be contributed to more males having leadership roles representing FBOs. Although, this was a barrier, I was still was able to receive a total of fifteen study participants, which was the goal of the study.

Additional limitations were the faith leaders abilities to recall their experiences in providing health counseling to parishioners and remembering the outcomess given. This limitation was attributed to them giving accurate details of lived experiences to address the phenomenon in the study. Arranging the interviews with religious leaders, became very time consuming, which offered time restraints in the the data collection process. This was due to many of them having busy schedules and leading FBOs, however the task was achieved to set-up the fifteen interviews and complete the qualitative study.

Recommendations

After conducting this qualitative research study and reviewing the data, I would suggest future researchers to have an even larger sample size to open the opportunity for a wider range of interviews from faith leaders of various denomination and religions.

Although saturation was accomplished, an even greater sample size would offer a richer description coming from the faith leaders. Having multiple faith leaders from denominations and religions not represented in this study, will be useful in adding a different voice to the research findings.

Another recommendation is having the data reach other areas than Northeastern NC. Expanding the study to other Southern would allow for states different participant pool of faith leaders. This may be accomplished by sending out surveys and changing the approach from qualitative to quantitative, to reach a larger sample size. Expanding to additional states will also offer research findings to be reviewed by additional colleagues, that share common goals of providing aid to FBOs.

Additional research should focus on obtaining data needed to validate reasoning to offer formal training, coaching, and mentoring that motivate faith leaders strategies to offer health advice and information to parishioners. Faith leaders need the guidance to identify parishioners with expertise in health promotion, to develop health ministries that would potentially take the burden from them, in locating resources for members. They need support to be provided by health professionals or the local health department in their community if they are unable to provide parishioners with the health advice requested, to evoke positive health outcomes. Also, seminaries should be contacted and given suggestions from the research results, to show evidence of faith leaders requesting guidance and training to come from the institutional level. Institutions should focus on providing health counseling/training to them. There should be resource list developed for

faith leaders, showing them how to direct members to the correct professionals, for those seeking medical advice from them beyond their expertise.

Implications

The findings from the study have the implications to evoke social change to heighten faith leaders sense of responsibility and foster motivation and encouragement to utilize their leadership skills by leading parishioners, along with community to promote positive health outcomes. The research acknowledges that faith leaders can influence positive social change, by demonstrating encouraging health behaviors to the congregation and the community (Hipple & Duff, 2010). This research confirms all the faith leaders responses in recognizing the role they play in providing health resources to parishioners. FL8 responded, "A big part of my role is to help them make connections and direct them to resources." It is recognized that not all faith leaders have the ability to provide health resources, especially those FBOs in rural areas. Increasing the utilization of faith leaders who can reach underserved communities and empower them to make lifestyle changes will be powerful for social change for them on multiple levels.

It is significant on local, state, national, and global levels to recognize all obtainable resources that can be initiated to address the increasing numbers of mortality rates related to health disparities for communities. It was established in the research that faith leaders are considered a resource person for parishioners and the community by including concerns of health and finances (Bopp & Webb, 2012). These faith leaders are considered resourceful assets to medical institutions, public health organization, academic institutions, community organizations, and agencies on the location and private

sector. Long-term social change implications included the development of partnerships between these organizations and sharing the themes with public health organizations for future health promotion strategies to target faith-based communities. With the help from these organizations, faith leaders need to be educated, equipped, and directed to be advocates to accomplish social change in the communities they serve. They are currently providing social change concepts for their community and do most of the work without even knowing it. It is now documented through this research of faith leaders achieving social change for many populations and this data can be used to address health disparities to support research findings.

Conclusion

It is vital to understand experiences of faith leaders and their insight about providing health counseling to their congregation. Exploration and documentation of the insights of 15 faith leaders expressing their lived experiences, thoughts, and feelings was expressed by providing health counseling and by serving as a resource person. This study has filled the gap in the literature through engaging faith leaders through data collection to understand the training and skills needed for them to evoke social change, by providing health information to parishioners. Data collection from this study revealed that faith leaders are knowledgeable of health challenges affecting their congregation and are willing to seek outside resources to help the people they serve. They are also aware of their limited expertise in offering health information or counseling to parishioners when advice is requested. Although, they are not formally trained, the literature confirms they are trusted by the congregation and the community and in the best position

to provide strategic resources to address health disparities. Faith leaders not only have the spiritual knowledge, they are well-informed of how to motivate parishioners through their sermons and teachings.

This study may help health care professionals and various institutions better facilitate efforts to provide faith-based health resources, along with reaching congregations in Northeastern, NC and surrounding areas. Faith leaders' experiences may be shared with seminaries to help them understand the need to provide training and courses on counseling. If seminaries could offer specified training to clergy, this would be helpful for future graduates having the expertise to conduct or advise parishioners that may seek them for health advice. Overall, the data obtained from this research may be used to enhanced future studies receiving faith leaders' insights by promoting healthy outcomes among parishioners and their community.

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Appendix A: Interview Protocol

Research Title: Understanding Faith Leaders Experiences on Health Counseling Provided to their Congregation	
Time of Interview:	
Date:	
Place:	
Interviewer: LaTangee Dickens	
Interviewee:	
Position of Interviewee: Hi, my name is LaTangee Dickens and I attend Walden University as a dissertation student in Public Health. I want to first thank you for taking time out of your schedule for this interview. As mentioned on the consent form, the purpose of this study is to understand faith leaders insight on health counseling that may be conducted in their faith-based organization. I will be taking notes and also recording your responses. This interview should take no more than 30 minutes. I can also share the final research results of this dissertation research with you upon your request through email. I will be asking you questions concerning the topic and if you need a break at anytime, please let me know. May we begin with this interview?	
Questions	**Notes**
Demographic Questions Church Name: Estimated Number of Members: Denomination: Type of Faith Leader: Education: Faith Leader County of Residence: Church County of Residence:	

Age:	
1. How would you describe your role as a faith leader in providing health counseling to parishioners.	
a) Tell me more about that role…… b) What do the parishioners think your role is as a health counselor?	
2. How do you feel about your ability to conduct health counseling for parishioners that seek medical advice from you?	
a) Can you tell me more about your abilities….? b) What do you feel you are able to provide as a health counselor for parishioners?	
3. How have you addressed medical questions asked of you, by parishioners during counseling sessions?	

b) What were the outcomes?	
4. As a faith leader, what training or skills are needed when providing health counseling to support parishioners?	
5. How would you describe the influence of clergy in providing health information to parishioners through their teachings and sermons?	
a. In your opinion, does this motivate parishioners to improve their health behaviors? If so, please provide an example?	
6. Please describe the most common health-related issues you think parishioners suffer from the most in your congregation?	
a. What do you believe are the contributing factors causing these health-	

related issues mentioned?	
7. How could you motivate parishioners as a faith leader from podium or pulpit, if given the necessary health resources?	
a. How would you motivate parishioners to choose a healthier lifestyle and make better choices about their health?	
8. What are your thoughts on having a health promotion ministry in your congregation?	
a. Do you currently provide any health and wellness activities in your congregation? If so, can you provide details about those health and wellness activities? b. Please describe any health and wellness programs you have heard of or read about, that you feel may be beneficial to your congregation?	

I have no further questions to ask you, however is anything you would like to add or say concerning the questions that have been asked? Thank you again for participating in this interview	

Appendix B: Interview Questions

1. How would you describe your role as a faith leader in providing health counseling to parishioners.

c) Tell me more about that role……

d) What do the parishioners think your role is as a health counselor?

2. How do you feel about your ability to conduct health counseling for parishioners that seek medical advice from you?

c) Can you tell me more about your abilities….?

d) What do you feel you are able to provide as a health counselor for parishioners?

3. How have you addressed medical questions asked of you, by parishioners during counseling sessions?

a) What were the outcomes?

4. As a faith leader, what training or skills are needed when providing health counseling to support parishioners?

5. How would you describe the influence of clergy in providing health information to parishioners through their teachings and sermons?

a. In your opinion, does this motivate parishioners to improve their health behaviors? If so, please provide an example?

6. Please describe the most common health-related issues you think parishioners suffer from the most in your congregation?

b. What do you believe are the contributing factors causing these health-related issues mentioned?

7. How could you motivate parishioners as a faith leader from podium or pulpit, if given the necessary health resources?

a. How would you motivate parishioners to choose a healthier lifestyle and make better choices about their health?

8. What are your thoughts on having a health promotion ministry in your congregation?

a. Do you currently provide any health and wellness activities in your congregation? If so, can you provide details about those health and wellness activities?

b. Please describe any health and wellness programs you have heard of or read about, that you feel may be beneficial to your congregation?

Appendix C: Background of Expert Panel

Expert 1:

The first expert is a male pastor residing in North Carolina, who is the founder of a well-known church resource portal, which covers a broad range of religions. He holds a Ph. D in Divinity and has been pastoring for over 25 years.

Expert 2:

The second expert is a female senior nurse vice president, working at a local medical center. She manages a faith-based health program that reaching faith leaders in a 29-county region in Eastern North Carolina.

Expert 3:

The third expert is a female holding a coordinator position, working for a non-profit organization that provides resources and grant funding to faith-based organizations in North Carolina.