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ORIGINAL PAPER

A Qualitative Study of Faith Leaders' Perceptions of Health and Wellness

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Abstract The effectiveness of faith-based health and wellness interventions is moderated by the attitudes, perceptions, and participation of key leaders within faith-based organizations. This qualitative study examined perceptions about the link between health, spirituality, and religion among a volunteer sample of faith leaders ($n = 413$) from different denominations. The major themes included: influences on health and wellness promotion and a relationship between spirituality and health. The results indicated that perceptions about the link among health, spirituality, and religion vary among faith leaders, regardless of denomination. Future faith-based interventions should be developed with consideration for denomination as a socially and culturally relevant factor.

Keywords Health · Spirituality · Faith-based interventions

Introduction

The four leading causes of death in the United States are heart disease, cancer, chronic lower respiratory disease, and stroke (Miniño et al. 2010). Some of the risk factors for these diseases (e.g., sedentary lifestyle, poor diet) are modifiable, prompting government organizations to seek and identify health promotion interventions that are successful at reducing risk factors and preventing chronic disease. Developing partnerships within the community at multiple levels is a vital aspect of successful health promotion interventions (Centers for Disease Control and Prevention 2001). In accordance with the goals of Healthy People 2020 (U.S. Department of Health and Human Services 2010), health promotion interventions should seek to develop and foster a "social and physical environment" that is conducive to a healthy lifestyle. Institutions, such as faith-based organizations, are part of

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the social and physical environment of a community and have been the site of recent health promotion interventions.

Faith-based organizations are ideal partners due to the potential for widespread reach of initiatives. Among Americans affiliated with a particular religion, approximately 76% ascribe to Christianity and approximately 27% of Christians attend religious services at least once per week, with an additional 17% attending at least once a month (Pew Research Center 2008b). Further evidence that the church is an ideal site for health promotion interventions reaching the general population, as well as underserved groups, is seen in a recent survey in the United States of 811,895 adults that indicated church attendance is highest among African Americans and older adults (Newport 2010). This exemplifies the important role the church can play in the goal of reducing health disparities in the United States and reaching other underserved groups (U.S. Department of Health and Human Services 2010).

Faith-based organizations (FBOs) have been effective community partners for health promotion interventions (DeHaven et al. 2004). Current literature has outlined several successful faith-based health promotion interventions (Bopp et al. 2009; Campbell et al. 2004; Duan et al. 2000; Duru et al. 2010; Kim et al. 2006; Schorling et al. 1997; Voorhees et al. 1996; Wilcox et al. 2007; Wilcox et al. 2010). Although African American Protestant churches have been the frequent site for these interventions, there has been increasing interest in implementing interventions in other religions, denominations, and racial or ethnic groups (Krukowski et al. 2010; Padela et al. 2010). The reproduction of successful interventions in other FBOs should be preceded by a comprehensive evaluation of their customs and beliefs to allow for tailored health communication materials that are culturally and socially relevant (Hawkins et al. 2008). Culturally tailoring interventions will increase the likelihood that it will be favorably received and subsequently more effective at changing health behaviors (Noar et al. 2007). For the same reasons, careful consideration should be given for the beliefs of the leader of the FBO. Most FBOs have a designated primary faith leader that is the spiritual and operational head of the institution and is generally supported by associate pastors, administrative staff, and/or a board of deacons, all of whom play an important role in supporting the mission of the church. Cultural tailoring necessitates that this hierarchy is understood, respected, and appropriately navigated to ensure acceptability and solidify partnerships between health promotion professionals and FBOs.

In addition to tailoring the intervention to garner support from the faith leaders in the FBO, faith leaders should be included as active participants in the intervention. A review of faith-based health promotion interventions revealed that the effectiveness of faith-based health promotion interventions is often moderated by the participation and support of the faith leader (Peterson et al. 2002). More specifically, the faith leader needs to be recognized as the most influential voice in the FBO and attaining their "blessing" is vital to the success of the intervention (Campbell et al. 2007; Demark-Wahnefried et al. 2000). The participation and support of faith leaders in an intervention may depend on their attitudes and perceptions regarding the purpose of the intervention. Although some studies have examined faith leader perceptions regarding the role of the church or congregation in promoting health and wellness (Catanzaro et al. 2007), none have examined if perceptions vary by denomination. The three major Christian denominations are Protestant, Catholic, and Orthodox, and within the Protestant denomination there are numerous sub-denominations (ARDA 2000). In light of this, generalizing faith leader perceptions regarding matters of health and wellness is unreasonable. Tailoring at the deep-structure level requires that differences and similarities between denominations, and possibly even within individual churches, be appreciated to develop effective health promotion interventions

(Resnicow et al. 1999). Therefore, the primary goal of this study was to qualitatively examine faith leader perceptions about the link among health, spirituality, and religion.

Methods

Design

This was a cross-sectional study conducted using an online survey system (Axio Learning Systems, Manhattan, KS). The entire survey included both closed-ended questions addressing health and wellness programming in FBOs and an open-ended survey question to qualitatively examine faith leader perceptions about the link among health, spirituality, and religion. This study was approved by the institutional review board.

Sampling

For this study, we used a convenience sample of faith leaders from across the United States. Pew Forum statistics (Pew Research Center 2008a) were used to identify the top three denominations in each state. We then visited the Web site of the denomination's state-level governing organization and gathered as many e-mail addresses as possible for faith leaders and/or administrative staff of FBOs associated with the governing organization. An initial e-mail requesting participation in "A Survey on Faith and Health" was sent to 13,644 unique e-mail addresses. E-mail reminders were sent 2–3 weeks after the initial e-mail.

Some of the e-mails were returned as undeliverable ($n = 1468$) (11%). During the data collection period (March-December, 2009), the survey was accessed by 1012 individuals, of whom 844 completed the survey (6.9% response rate, 83% completion rate). Among these 844 respondents, 413 answered the open-ended survey question (49%). This study will only include data from those individuals who completed the open-ended question, although additional data from this survey can be found elsewhere (Bopp and Fallon, in press, under review).

Measures

Sociodemographics

Faith leaders reported on their age, race/ethnicity, sex, marital status, ministry position, education level, self-described denomination, height, and weight. Body mass index (BMI) was calculated using self-reported height and weight (American College of Sports Medicine 2009).

Health and Wellness Perceptions

Faith leaders were provided an open-ended response field and asked to "describe any thoughts you have on the link between health, spirituality and religion."

Statistical Analysis

For the purpose of analysis, denominations were categorized according to affiliation with a major denomination. For example, Evangelical Lutherans and Missouri Synod Lutherans

were included in the single category of Lutheran. In many cases, participants did not specify a specific denominational affiliation beyond the major denomination (e.g., Lutheran). Denominations with fewer than ten faith leaders providing comment were combined into an "Other" category. All statistical analyses were conducted using PASW Statistics, v18 (IBM, Somers, New York). Basic frequencies were conducted for the demographic variables. We used t-tests and chi-square analyses to examine differences in the larger data set between those individuals that responded to the open-ended question to those who did not.

Qualitative Analysis

All qualitative analyses were conducted using QSR NVivo, v8 (QSR International, Cambridge, Massachusetts). Two investigators independently read the responses thoroughly and, using thematic analysis (Patton 2002), discussed and agreed upon major themes with corresponding sub-themes. For example, a major theme was "institutional influences on health and wellness promotion" and a corresponding sub-theme was "supportive church doctrine." Codes were developed for all themes and sub-themes. The responses were then coded independently by two investigators and then compared to resolve any disagreements. Basic frequencies of coded responses were performed for each denomination.

Results

Participant Characteristics

The demographic characteristics of the respondents that answered the open-ended survey question ($n = 413$) are provided in Table 1. The majority of respondents were men (72%), and all respondents were Caucasian. The average age of the respondents was 54.25 years (SD = 11.31). Most respondents were married (82%). Most of the respondents were the primary faith leader (e.g., lead pastor) of their FBO (73%). The majority reported having an advanced degree (Masters or PhD) relevant to their ministry role (78%). The most common denominations reported were Methodist (41%) and Lutheran (21%). Nineteen percent of respondents were normal weight (BMI 18.5–24.9 kg/m^2), with the remaining being either overweight (35%) (BMI 25-29.9 kg/m^2) or obese (46%) (BMI $\geq$ 30 kg/m^2). Chi-square analyses indicated that faith leaders that responded to the open-ended question did not differ demographically (i.e., race, sex, marital status, ministry position, or education level), with the exception of age, than those that did not respond to the question. *T*-tests indicated that the mean age of faith leaders that responded to the open-ended question (52.65 $\pm$ 11.30 years) was significantly less than the mean age of the faith leaders that did not respond (54.25 $\pm$ 11.32) ($t = -1.994$, $df = 793$, $p = 0.046$). Chi-square analyses indicated that there was a significant relationship between faith leader denomination and whether a faith leader responded to the open-ended question or not ($\chi^2 = 29.796$, $df = 5$, $P < 0.001$), with Church of Christ faith leaders more likely to respond to the question compared with other denominations.

Themes

The major themes that emerged were *barriers to promotion of health and wellness* (e.g., congregational, community resources, lack of knowledge or expertise for the faith leader,

Table 1 Sociodemographic characteristics of the sample ($N = 413$)

Characteristic	Value
Age, years (SD)	54.25 (11.31)
% Caucasian	100
% Male	72.3
Marital status	
% Married	81.8
% Widowed	1.6
% Divorced	3.9
% Single	12.8
Ministry position	
% Primary faith leader (e.g., lead pastor)	72.8
Education (relevant to ministry role)	
% Less than bachelors degree	5.9
% Bachelors degree	3.4
% Post-bachelors certificate	5.3
% Masters degree	65.6
% Doctoral degree	12.8
% Other	7.0
Denomination	
% Methodist	40.7
% Catholic	14.1
% Baptist	12.1
% Lutheran	20.1
% United Church of Christ	5.3
% Other	7.7
Body mass index (kg/m^2)	
% Normal weight	18.9
% Overweight	35.4
% Obese	45.7

lack of time for the faith leader, and personal), *institutional influences on health and wellness promotion* (e.g., supportive or unsupportive church doctrine), and *spirituality and health link* (e.g., faith or religious support for link, view wellness as holistic, reference to specific scripture supporting link, and acute illness or coping with disease). Percentages presented hereafter in the results are representative of that specific denomination and not of the entire sample.

Barriers to Promotion of Health and Wellness

References to barriers for health and wellness promotion and some additional illustrative responses are provided in Table 2. A number of Church of Christ faith leaders (26%) stated that the congregation was a barrier to promoting wellness. In regard to congregational barriers, a Catholic leader acknowledged that, "…many people do not see religion as the base for thinking about health issues and particularly health related activities." Some Lutheran respondents (6.1%) stated that the availability of resources in the community dissuaded them from promoting health and wellness in their church. Some Baptist leaders

Table 2 Barriers for health and wellness promotion: frequencies and select responses ($N = 413$)

Theme	Frequencies by denomination (N, %)[a]	Illustrative quotations
Congregational (e.g., no interest)	Baptist (2, 4.0%) Catholic (7, 12.1%) Church of Christ (5, 26.3%) Lutheran (6, 7.3%) Methodist (15, 8.7%) Other (5, 15.2%)	"…I'm not sure that the congregation always understands the Biblical worldview of health and well-being. Often this subject promotes a worldview contrary to scripture."—Methodist female
Community resources (e.g., programming exists elsewhere)	Baptist (2, 4.0%) Catholic (2, 3.4%) Lutheran (5, 6.1%) Methodist (3, 1.8%) Other (1, 3.0%)	"The average age of our congregation is more than 70 years old and they get the education they need from a variety of other services. …We have seen no need to duplicate these activities at our church."—Baptist male
Lack of knowledge/ expertise for the faith leader	Baptist (2, 4.0%) Methodist (3, 1.8%)	"I don't feel like I have the knowledge to know where to find the resources to talk about [health] more."—Methodist female
Lack of time for the faith leader	Catholic (2, 3.4%) Church of Christ (2, 10.5%) Lutheran (2, 2.4%)	"There just aren't enough hours and volunteers to cover everything we want to do."—Church of Christ female
Personal barriers (e.g., self-efficacy)	Baptist (1, 2.0%) Church of Christ (1, 5.3%) Lutheran (2, 2.4%) Methodist (7, 4.1%) Other (1, 3.0%)	"…Therefore, I feel like a hypocrite to stand in the pulpit and teach people God's word about taking care of our bodies when I, by all physical appearances, do not seem to be doing it myself."—Baptist male

[a] Values following denomination (N, %) are specific to that denomination and not representative of entire sample

(4.0%) mentioned a lack of knowledge or expertise in health and wellness as a barrier to health promotion. A small number of Church of Christ leaders (11%) cited a lack of time necessary to engage in the promotion of health and wellness as a barrier. A few Methodist leaders (4.1%) reported that they lacked self-efficacy for promoting health and wellness in the church, with one Methodist leader stating, "The clergy in our denomination are not good role models of physical health—in fact we are poor role models. Most clergy are overweight and do not exercise enough (if at all) or eat a nutritional diet."

Institutional Influences on Health and Wellness Promotion

References to institutional influences on health and wellness promotion and some additional illustrative responses are provided in Table 3. Leaders from Other (15%) and Methodist (14%) denominations stated that the promotion of health and wellness was part of the mission of their church. A Methodist leader likened health and wellness to an obligation, stating that, "The United Methodist Church as a whole has often viewed health and wellness as something to encourage parishioners to participate in, much like voting or staying in school." This view is contrasted by a number of Church of Christ leaders (26%) that claimed health and wellness was not part of the mission of their church. This view was not consistent among all Church of Christ leaders, as one respondent asserted that his

Table 3 Institutional influences on health and wellness promotion: frequencies and select responses ($N = 413$)

Theme	Frequencies by denomination (N, %)[a]	Illustrative quotations
Supportive Doctrine (part of mission)	Baptist (3, 6.0%) Catholic (5, 8.6%) Church of Christ (1, 5.3%) Lutheran (2, 2.4%) Methodist (24, 14.0%) Other (5, 15.2%)	"I highly endorse the concept of holistic health: physical, spiritual, emotional/mental, and social. We intentionally design ministries to incorporate all facets."—Methodist female "The church is to promote growth and care of the whole person, body, mind, and spirit."—Baptist male
Unsupportive Doctrine (not part of mission)	Baptist (7, 14.0%) Catholic (3, 5.2%) Church of Christ (5, 26.3%) Lutheran (8, 9.8%) Methodist (3, 1.8%) Other (4, 12.1%)	"[Jesus] never instructed the church to teach on health, but to preach the Gospel, baptize the converts and teach them how to live the Christian life. Any organized ministry that does not further those goals of the church are the innovations of men and not authorized by the Lord."—Baptist male "Our leadership works hard to keep the church focused on our mission to make disciples of Jesus Christ, and we would see most of the things described in these questions [in the survey] as good things but, in our context anyways, as distractions from our mission."—Other male

[a] Values following denomination (*N*, %) are specific to that denomination and not representative of the entire sample

church "promotes a holistic approach to a person's well-being." A Baptist leader also shared the belief that the sanctuary was not the proper place for health promotion, stating that they would "discuss health issues one-on-one or in small groups, but do not address them directly from the pulpit because of the lack of scriptural support to do so." Likewise, a Lutheran faith leader claimed, "[The church] may, in fact, encourage its people to take care of their physical health—and that would be good—but it is NOT the purpose of the church."

Spirituality and Health Link

References to a link between health and spirituality and additional illustrative responses are provided in Table 4. Baptist (52%) and Lutheran (31%) leaders were among those that cited support in their faith or religion for the link between health and spiritually. In accord, a Baptist leader stated, "As Christians, we are called to take of our body, as it is the temple of God. However, because of whatever excuses we can come up with, we neglect to teach these Biblical truths of physical wellness." Yet another Baptist leader stated that, "Physical health is an important aspect of stewardship" and cited specific scripture supporting the idea that maintaining health is a "reasonable service and spiritual act of worship" (1 Cor 6.19–20). Several Church of Christ (63%), Methodist (48%), Lutheran (48%), and Catholic (43%) leaders held the common view that wellness was holistic. This was notably illustrated by a Catholic leader that stated, "I am concerned with 'wholeness', which for me includes the body, mind and the spirit (or soul). A complete, healthy person finds strength in each of these areas and finds a sense of personal fulfillment as these needs

Table 4 Spirituality and health link: frequencies and select responses ($N = 413$)

Theme	Frequencies by denomination (N, %)[a]	Select responses
Faith or religious support for link	Baptist (26, 52.0%) Catholic (6, 10.3%) Church of Christ (4, 21.1%) Lutheran (25, 30.5%) Methodist (38, 22.2%) Other (8, 24.2%)	"A Christian rightly regards his body and soul, intellectual faculties, material possessions, his health, and all he has as gifts of God and himself as a steward of the same. Thus, a Christian will see his health as something to be maintained as a good steward of God's gifts."—Lutheran male
View wellness as holistic	Baptist (18, 36.0%) Catholic (25, 43.1%) Church of Christ (12, 63.2%) Lutheran (36, 43.9%) Methodist (82, 47.9%) Other (11, 33.3%)	"Health, wholeness, and holiness are very closely related and integral to our humanity. Good health is a condition of physical, mental, social and spiritual well-being and is essential to one's full participation in community."—Methodist male
Reference to specific scripture supporting link	Baptist (7, 14.0%) Lutheran (2, 2.4%) Methodist (4, 2.3%) Other (3, 9.1%)	"For health and wellness are of some value, but Godliness has value for all things…"—Lutheran male paraphrasing 1 Timothy 4:8
Acute illness/coping with disease (i.e., relate wellness to helping people cope with illness/disease)	Baptist (1, 2.0%) Catholic (6, 10.3%) Church of Christ (1, 5.3%) Lutheran (8, 9.8%) Methodist (13, 7.6%) Other (2, 6.0%)	"…much of what I do as a faith leader is a reaction to a situation of physical illness (cancer, depression, addiction, stress, etc.—providing emotional and spiritual support) rather than promoting preventative measures."—Church of Christ female

[a] Values following denomination (N, %) are specific to that denomination and not representative of the entire sub-sample

are met." Some Baptist leaders (14%) referenced specific scripture verses that supported the link between health and spirituality. One scripture verse that was cited said, "Do you not know that your body is a temple of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore honor God with your body. (I Cor. 6.19–20 New International Version)" A theme that emerged among a few Catholic (10%) and Lutheran leaders (10%) was that health and spirituality were addressed solely in the context of sickness and disease, with one Catholic leader stating that, "Unfortunately, health issues are not usually addressed until they become critical. Roman Catholics tend to wait until they have to summon the priest for 'last rites'."

Discussion

This study indicated that perceptions about the link between health and spirituality vary among faith leaders, regardless of denomination. It also illustrated the differences of opinion in regard to whether FBOs should be concerned with matters other than spiritual health. There was a shared belief across all denominations that physical and spiritual health was linked. It was also acknowledged that there was support for the link between health

and spirituality in the faiths or religions of the respondents. Some respondents provided scripture support from the Bible regarding the importance of taking care of one's physical health as an act of stewardship (i.e., spiritual obligation).

Although many faith leaders acknowledged the value of physical health, there were strong opposing views regarding whether the church should engage in the promotion of health as part of its mission. Some faith leaders felt that the mission of their church included caring for both physical and spiritual health, and in some instances, referenced the current programs they offered in support of this mission. In contrast, other faith leaders strongly objected to their church participating in the promotion of anything other than matters of a spiritual nature and cited lack of scriptural support as a reason. Adding to the complexity of the results is that, even among respondents from the same major denomination, there were polarizing views about the role of the church in promoting health. These findings differ from those of Hale and Bennett (2003), whose research demonstrated strong support among a majority of faith leaders for the church's involvement in promoting health and health-related services. It is important to note, however, that unlike our study, Hale and Bennett used Likert-type scales to ascertain support for health promotion. Accordingly, our results should be viewed in the context that we did not offer any guidance regarding the outcomes we were interested in with our open-ended question. In the future, we can use what was learned in this study to develop quantitative scales to assess faith leader perceptions of health and spirituality, as well as the appropriateness of the FBO in promoting health and wellness.

An interesting finding of our study was the inner-denomination variance of leaders' opinions on whether the church should participate in the promotion of health and wellness. This could be a result of the means by which we categorized respondents into general denominations (e.g., Baptist included Southern Baptist, American Baptist, etc.). This is further complicated by the fact that some denominations (e.g., Southern Baptists) are autonomous and have experienced ideological rifts in years past, sometimes resulting in appreciably different philosophies between individual churches within the same denominations (Breen 2008). Alternatively, it is possible interpersonal differences of opinion regarding major issues concerning the church were expressed more openly due to the anonymity offered by the survey. Our results indicated that faith leaders share opposing views about the mission of the church as it relates to health promotion regardless of denomination, perhaps indicating the importance of the individual faith leader in promoting health and wellness within individual churches. Therefore, it is also worth considering the disagreement that might arise in individual interpretations of Biblical text. Faith leaders have historically come to different conclusions about the meaning of specific scriptures and the application thereof. For example, the Protestant Reformation was caused in part by conflicting views on the way scripture should be interpreted (Hillebrand 2009). These findings reveal the need for further research to better understand the inner-denominational differences among faith leaders regarding the role the church should play in promoting health.

The current literature suggests that the support and participation of faith leaders is an important factor in the success of faith-based interventions (Bopp et al. 2007; Campbell et al. 2007; Campbell et al. 2000; Demark-Wahnefried et al. 2000; Peterson et al. 2002). If the definitive goal of faith-based health promotion interventions is to encourage lasting institutional change, these findings suggest that interventions should be based, at least in part, on organizational change theory. Considering the variance in perceptions among faith leaders from the same major denomination, it would be prudent to explore intra-organizational change theories (e.g., Stage Theory) rather than theories designed to explain change *across* organizations. The Stage Theory of Organizational Change asserts that upper-level management (e.g., faith leaders) be enlisted first and foremost in the process of

organizational change (Butterfross et al. 2008); therefore, it is vital to understand the beliefs, perceptions, and values of the faith leader and the possible implications for implementing health promotion programs.

Only a few faith leaders commented on barriers to promoting health and wellness in their FBO, and though this may be due to the nature of the open-ended question, or that we did not specifically ask about barriers, further research is needed to identify the salient barriers to promoting health and wellness in FBOs. For instance, some faith leaders cited their congregation's lack of interest as a barrier to health promotion, but the basis for this claim is unclear in the responses. Surveying the membership of FBOs targeted for an intervention could provide insight into the likelihood that a health intervention would be favorably received or adopted by the congregation. Also of importance are the faith leaders who stated that they felt they were a poor role model for healthy behaviors, indicating that lack of self-efficacy among faith leaders could be a salient barrier to health promotion in FBOs.

The references to maintaining one's health as an act of stewardship provide possible strategies that can be implemented in promoting health and wellness in the church and in the recruitment of layperson volunteers for health and wellness programming. This study provided some evidence to suggest that promoting a consistent, tailored message focused on holistic health and "wholeness" would be appropriate and salient in this setting. Further contributions to this growing body of knowledge could be made by conducting similar studies with other religious groups (e.g., Muslim and Jewish faith leaders). This could provide insight into whether perceptions about health and spirituality differ among religions, as well as the appropriateness of faith-based interventions in settings other than the Christian church.

There are a few study limitations that should be considered when interpreting our results. First, we used a convenience sample of faith leaders. As this was strictly exploratory research, we felt this was a suitable alternative to more cost-prohibitive probability sampling methods. Consequently, our sample was limited to individuals with valid e-mail addresses affiliated with the largest denominations. Second, the low response rate to the survey could be indicative of a volunteer bias (e.g., respondents being more health conscious than non-respondents). However, 81% of the respondents in our survey were overweight or obese, which is similar to another study that had a 95% response rate (Proeschold-Bell and LeGrand 2010), suggesting that the low response rate in our study was not specifically due to a health bias. Third, the majority of the respondents to the general survey and the open-ended question were white, which limits the generalization of the findings to faith leaders and institutions of different ethnicities. Lastly, we used a single open-ended survey question to assess the health and wellness perceptions of the faith leaders. Future studies may be better informed by the use of interviews, focus groups, or forced-choice questions regarding health and wellness perceptions.

These limitations withstanding our study contribute to the growing body of knowledge concerning health promotion in faith-based organizations. It demonstrates the differences of opinion that exist among faith leaders and provides direction for future studies aimed at assessing wellness perceptions among faith leaders. It also provides support for the need to custom-tailored interventions targeting FBOs.

Conclusion

As an institution, FBOs are ideal for health promotion interventions due to their broad reach and influence. The influence of the FBO is typically channeled through key leaders

within the organization. This qualitative study reveals that faith leaders' perceptions about the link among health, spirituality, and religion are varied. Our findings illustrate the need to consider the beliefs and attitudes of faith leaders as socially and culturally relevant factors in the design of future faith-based interventions. The divergence of opinion between faith leaders of the same denomination exemplifies the need for extensive formative research when developing faith-based interventions. Although our study provides support for this idea, rigorous research is recommended to demonstrate whether faith-based interventions need to be developed specific to each church rather than by denomination alone to be as culturally tailored and effective as possible. The attitudes and beliefs of faith leaders of individual FBOs should provide sufficient impetus for interventionists to decide whether to delay implementing an intervention until the environment is more supportive. Although additional investigation is warranted, developing strategic partnerships with FBOs should be a priority of health professionals due to the potential to influence the health behaviors of a large segment of the US population, especially those affected most by health disparities.

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