

**Planning and Evaluating Faith-based Interventions:
A Framework to Close the Theory-Practice Divide**

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Faith-based interventions have proliferated across disciplines and denominations, ranging from programs developed by religious corporations with millions in revenue to those developed by grassroots organizations with nominal budgets; from ancient religious practices that have been Westernized, secularized and popularized to novel practices developed by religious congregants; from mission-driven secular services to faith-infused services that combine professional and religious practices to achieve temporal goals — all claiming to be effective. But in this thicket of revolutionary growth, it is difficult to distinguish promising practices. In fact, John DiIulio, former director of the White House Office of Faith-based and Community Initiatives (OFBCI) admitted “we've created an office out of anecdotes” (Goodstein, 2001). We do not yet know whether “it is the “faith” in the “faith factor,” independent of other organizational features and factors, that accounts for any observed differences in outcomes (DiIulio, 2002).

By what criteria should faith-based interventions be evaluated? Which practices are most likely to yield the desired results? Which, if any, frameworks facilitate comparative analysis of faith-based interventions within disciplines, with their secular counterparts, or across denominations? These questions are difficult to answer due, in part, to a lack of conceptual and definitional consensus and weak links between theory and practice that have resulted in methodologically flawed research (Johnson, Tompkins & Webb, 2002; Borkman, 1997; Fuller & Hiller-Sturmhofel, 1999).

Conceptual Problem

To date, the social work perspective has eclipsed other professions in the faith-based intervention discourse, largely because the government’s focus on Charitable Choice and social programs. This privilege persists despite a dearth of rigorous social work research. However, a

voluminous body of medical research documents the salutary effects of religion and spirituality on well-being (Larson, Sherrill, Lyons et al, 1992; Johnson, Thompkins & Webb, 2002; McCullough et al, 2000; Propst et al, 1992; Koenig, George & Peterson, 1998; Krause, 1998; Larson et al, 1992; Cole & Pargament, 1999; Chatters, Levin & Ellison, 1998; Krause, et al, 1999). Findings from these studies are potentially transferable to faith-based interventions (Chatters, 2000). However, the extent to which extant research and measures have been intentionally integrated into intervention planning and evaluation is largely unexamined.

Further, myriad faith-based interventions have emerged from “folk” wisdom in faith communities, based upon tacit rather than empirical knowledge of what works. Those folk theories are essential for developing more effective and culturally relevant interventions (Gaventa, 1993; Kidder & Judd, 1986; Pena & Gallegos, 1997; Werner & Brower, 1982; Thackeray & Neiger, 2000; Rimer, Glanz & Rasband, 2001). Yet documentation of them is limited, at best.

Practitioners need a comprehensive framework for planning faith-based interventions that accommodates multiple theoretical and denominational perspectives; integrates formal and local knowledge of best practices and; delineates structural and procedural variables that might account for observed differences in intervention outcomes. Ideally, such a framework would propel the field from faith-based to evidence based practice.

This paper seeks to bridge the theory-practice divide by first explaining the concept of evidence-based practice. As part of the evidence-based process, I will integrate formal knowledge published in academic journals and informal knowledge from faith communities to identify known best practices. First, I present an exemplary model for general intervention planning, followed by a brief review of religion and well-being research. This formal knowledge

delineates key variables for the conceptual framework that will be presented, and which may be fortified by indigenous but untested practices originating in faith-communities.

THEORETICAL BACKGROUND

From Faith-based to Evidence-based Practice

Evidence-based practice is a structured decision making framework that helps medical professionals and patients “choose the best available healthcare interventions for the outcomes they are seeking” (Donald, 2002). Evidence-based medicine has informed thousands of clinical and policy decisions and helped to prevent seemingly logical yet potentially harmful policy and practice decisions in various disciplines (Donald, 2002). The process consists of four steps: 1) defining structured questions about the target population, outcomes, intervention and/or exposure; 2) Searching published and unpublished sources for data that might answer those questions; 3) Appraising or evaluating the data for its rigor and relationship to the questions “(typically, this process weeds out about 90% to 99% of studies)” and; 4) Conducting analysis and relating results to the questions posed (Donald, 2002).

I will focus on step two by reviewing published and unpublished (i.e., not in academic journals) to understand which frameworks might lead to more effective faith-based intervention planning and evaluation.

The PRECEED-PROCEED Model of Health Promotion Planning

PRECEED-PROCEED is the widely accepted "gold standard" for designing, implementing and evaluating micro and macro level preventive interventions, the goal of which is to systematically reduce the occurrence of conditions that compromise well-being (Green & Kreuter, 1999). The model is grounded in multi-disciplinary theories that view health issues as phenomena that are embedded in relatively consistent and enduring behavioral patterns. Further, its ecological perspective of health education targets individuals, their social network, organizational and social contexts, and related policies. Hence, the model delineates structural and procedural variables that are germane to faith-based interventions.

PRECEED, an acronym for **P**redisposing, **R**einforcing, **E**nabling Constructs in **E**ducational/**E**cological **D**iagnosis, is a planning phase that assesses social and situational conditions, epidemiology, behavior and environment, and educational and ecological factors that influence health behavior. Predisposing factors are both *cognitive* and *affective*. They include knowledge, beliefs (or doubt), values, attitudes, self confidence, a sense of self-efficacy and behavioral intention, which determine the motivation to act in concert with or contrary to stated intervention goals. When information is presented in an engaging and culturally sensitive manner, and participants share common values, beliefs and attitudes, the likelihood of effectiveness increases.

Enabling factors are both *individual* and *structural*. Individual enabling factors include existing or acquired skills that equip individuals to behave in healthy ways. Structural enabling factors, such as location, organizational culture and norms, symbols, rituals, and models, determine the ability to engage in health promoting behaviors, the availability of existing resources, and the organization's priorities and commitment. These contextual factors are strengthened via policy changes in the immediate organization and community, or in the broader social context.

Reinforcing factors are the positive or negative consequences of behaviors that one experiences via communication from their social context (e.g. family, friends, teachers, leaders, clergy) in the form of feedback, recognition, rewards, punishment or changes in the immediate or broader culture. Behavior consequences, such as self monitoring or improved appearance, may also be reinforcing (e.g.). Or behavior may be reinforced vicariously when participants observe a highly esteemed person being rewarded for engaging in behaviors that promote or compromise health (Green & Kreuter, 1999).

PROCEED is an acronym for **P**olicy, **R**egulatory, & **O**rganizational Constructs in **E**ducational/**E**cological **D**evelopment. In addition to examining policies and political forces that influence interventions, this phase also examines the organization's mission and policies; human and financial resource capacity, administration and implementation issues, and evaluative aspects

of the intervention (Green & Kreuter, 1999). “PROCEED assures that the program will be available, accessible, acceptable and accountable” (Green & Kreuter, 1999:214).

The PRECEED-PROCEED model is a necessary but insufficient framework for analyzing faith-based interventions. It is limited in its inability to account for the specific ways in which faith, religion and spirituality mediate cognitive, affective and behavioral outcomes. In fact, Chatters, Levin & Ellison (1998:695) noted that “[a]spects of religious and spiritual beliefs and practice may directly reinforce, enable or predispose health-related behaviors, the functioning of socially supportive networks, and the manifestation of various psychosocial states, traits, and resources.” Thus, we turn to religion and well-being research.

Analyzing Faith Factors: Religion, Spirituality and Well-being Research

Dominant theoretical constructs such as religious involvement (Chatters, Levin & Taylor, 1992), spiritual well-being (Hawks et al, 1995; Chapman, 1987; Reed, 1987), religious coping (Pargament, 1997; Hathaway & Pargament, 1992) and functional mechanisms linking religion to well-being (Chatters, 2000; Chatters, Levin & Ellison, 1998) elucidate the ways in which faith factors may fortify PRECEED aspects of faith-based interventions. Although these constructs overlap, as illustrated in Table 1, each explicates distinct psychological, social and organizational faith mechanisms of interventions.

Religious involvement facilitates comparison of individual and organizational factors such as subjective, non-organizational and organizational involvement. Subjective involvement entails individual attitudes, beliefs and self perceptions. Non-organizational involvement refers to private religious practices such as prayer, consumption of religious media and devotional practices. Conversely, organizational involvement refers to denominational affiliation and attendance (Levin, 1989; Chatters, Levin & Taylor, 1992; Chatters, 2000). Research shows that religious involvement is linked to well-being. However, the texture of those experiences or *why* attendance or reading devotional materials might have salutary effects is unclear. Toward that end, theories of spiritual well-being are useful.

Theories of spiritual well-being identify intrapersonal, social, cognitive and numinous links between religion and well-being including: connection to self (e.g. introspection); connection to others; a sense of meaning, purpose and hope and; an awareness of a larger reality with some coherence and; a sense of connection to God or a larger force (Banks et al, 1984; Hawks, 1994). Interventions that promote spiritual well-being have been correlated with improved mood, physical health, reduced mortality rates (Hawks, 1995), and predict a variety of health behaviors (Waite et al, 1999). Conversely, spiritual ill-being has been identified as a causal factor in poor health and heart disease (Hawks et al, 1995). Ideally, spiritual well-being interventions result in spiritually motivated lifestyle changes rather than changes induced by fear or other external factors (Hawks, 1995).

Religious coping is another causal mechanism underlying religious involvement and spiritual well-being. For example, passive religious deferral means expecting God to solve one's problem, whereas active religious surrender means doing one's best while relying on God. Through situational coping, individuals seek lessons in events, view events as part of God's plan or as part of a strengthening process (Hathaway & Pargament, 1992; Pargament, 1997, 1999; Fetzer, 1999). Religious coping may also be used to prevent negative events, inoculate against stress, build competency, and provide spiritual comfort or divine support. However, some forms of coping such as feeling punished, abandoned, angry toward God or questioning God's existence can have adverse effects, and highlight the need to examine its salutary or iatrogenic effects on well-being (Pargament, 1997; White-Perkins, 2001).

Chatters, Levin & Ellison (1998; Chatters, 2000) identified other subcomponents of spiritual health by explicating functional mechanisms that describe the ways in which religiosity and spirituality moderate physical and psychological well-being such as: 1) regulation of individual lifestyles and health behaviors; 2) provision of social resources (e.g., formal and informal support); 3) promotion of positive self-perceptions (e.g., self-esteem, self efficacy); 4) provision of specific coping resources (i.e., cognitive or behavioral responses to stress); 5) generation of other positive emotions (e.g., love and forgiveness); 6) promotion of healthy

beliefs and; 7) additional hypothesized mechanisms, such as the existence of a healing bio-energy and the salutary effects of others' prayers.

Together, the PRECEED phase of intervention, religious involvement, spiritual well-being and functional mechanisms connecting religion and health can be used construct a framework to guide faith-based intervention design, implementation and evaluation.

Compass to Guide Faith-based Intervention Planning & Evaluation

The basic premise of the typology for planning and evaluating faith-based interventions is that the best faith-based intervention practices will be synthetic practices; the most recent and empirically validated professional knowledge combined with continually discovered practices from different ethnic and religious communities.

Figure 1 depicts a “Compass to Guide Faith-based Intervention Planning and Evaluation.” It is analogous to a concentric compass in that it both circumscribes and guides. The compass is an apt icon because of its dynamic nature; in order to get a true reading of the range of faith-based interventions, it must be continually validated and corrected as new information is discovered and analyzed. Unlike a typical compass however, it does not point to a single direction; all directions must be traveled simultaneously for optimal results.

Cardinal Points on the Intervention Compass

Cardinal points indicate general directions (e.g., north and south). PRECEED factors, predisposing, reinforcing and enabling factors are the cardinal points on this intervention compass, denoted by red, yellow and blue, respectively. The inner compass, denoted by pale primary hues, highlights the core of secular PRECEED factors that ideally structures all interventions; it represents the scientific and culturally specific knowledge upon which an intervention is based.

The outer compass, denoted by intense primary hues, represents additional faith-based predisposing, reinforcing and enabling factors that fortify the secular core. More specifically, how secular activities becomes part of a search for the sacred (Hill, Pargament, Hood et al, 2000).

The ratios presented on both compasses are not fixed or necessarily indicative, but suggest that emphasis on each secular and faith-based PRECEED factor fluctuates depending upon individual, organizational and phenomenological variables; the compass must be recalibrated accordingly. Further, markers on inner and outer compasses are intentionally misaligned to indicate that emphasis on a particular secular PRECEED factor may not parallel the emphasis placed upon its faith-based counterpart. As more tacit knowledge about best practices is unearthed, integrated into interventions and analyzed, the appropriate ratios between secular and faith-based components will become clearer for certain types of interventions, populations and organizational cultures.

We might expect that some variables will be heavily faith-based and others weighted more toward the secular. For example, because of the centrality of predisposing factors in certain interventions and their role in promotive cognitive and affective change, we might expect predisposing factors to be heavily faith-based. In contrast, skill building may be based upon professional knowledge, weighting enabling factors more toward the secular. Planning interventions in this way facilitates analysis of the additive effects of discrete faith factors over and above comparable secular factors. But first, we need to define the intercardinal points that would facilitate such analysis.

Intercardinal Points on the Intervention Compass

Intercardinal points are more specific directional indicators such as northeast and southwest, within which are even more finely delineated degrees. The parallel here is subcategories within each PRECEED factor such as predisposing cognitive and predisposing affective factors, within which are more finely delineated activities. Tables 2 through 4 presents intercardinal points of PRECEED factors and discrete degrees or activities within them that can be used to plan and analyze faith-based interventions. For example, the columns in Table 2 shows predisposing cognitive and predisposing affective intercardinal points, which may be secular or faith-based. Each row represents degrees within each intercardinal point. A concrete example would be the use of scientific nutritional information to restructure health beliefs,

supplemented with religious doctrinal perspectives about food and nutrition. Descriptors of faith-based intercardinal points were derived from indigenous and professionally developed faith-based interventions (Campbell, Wahnefried, Symons et al, 1999; Campbell, Motsinger, Ingram, Jewell et al, 2000; Voorhees, Stillman, Swank, Heagerty, Levine, Becker, 1996; Stillman, Bone, Rand, Levine, Becker, 1993; Skinner, et al, 1998; Brown, 1937; Yanek, Becker, Moy, Gittelsohn & Koffman, 2001; Shamblin, 1997; <http://www.pfm.org>; <http://www.teenchallenge.com/>; [http://www. weighdown.com](http://www.weighdown.com)).

Discussion: Toward Evidence-Based Faith-based Interventions

The goal of this paper was to present a framework that links research and theory to practice. The “Compass to Guide Faith-based Intervention Planning and Evaluation” is an important first step toward cultivating best practices and weeding out inefficient ones. It is a synthetic model that is broad enough to accommodate theoretical constructs from multiple disciplines and to be augmented with knowledge from different faith traditions. It presents a range of faith-factors that may be integrated into interventions. In addition, it facilitates multiple levels of analysis, and will help to disentangle the effects of structural, procedural, social and doctrinal variables. Quantitative and qualitative data is needed to understand the relationship between those factors and intervention outcomes. Is faith truly the factor that influences results? If so, which factors -- structural or procedural? For which populations? Are the effects of faith additive? What kind of debriefing protocol is needed to analyze reasons for attrition? How do we effectively prevent spiritual alienation while promoting spiritual well-being? These are all questions that bear further analysis.

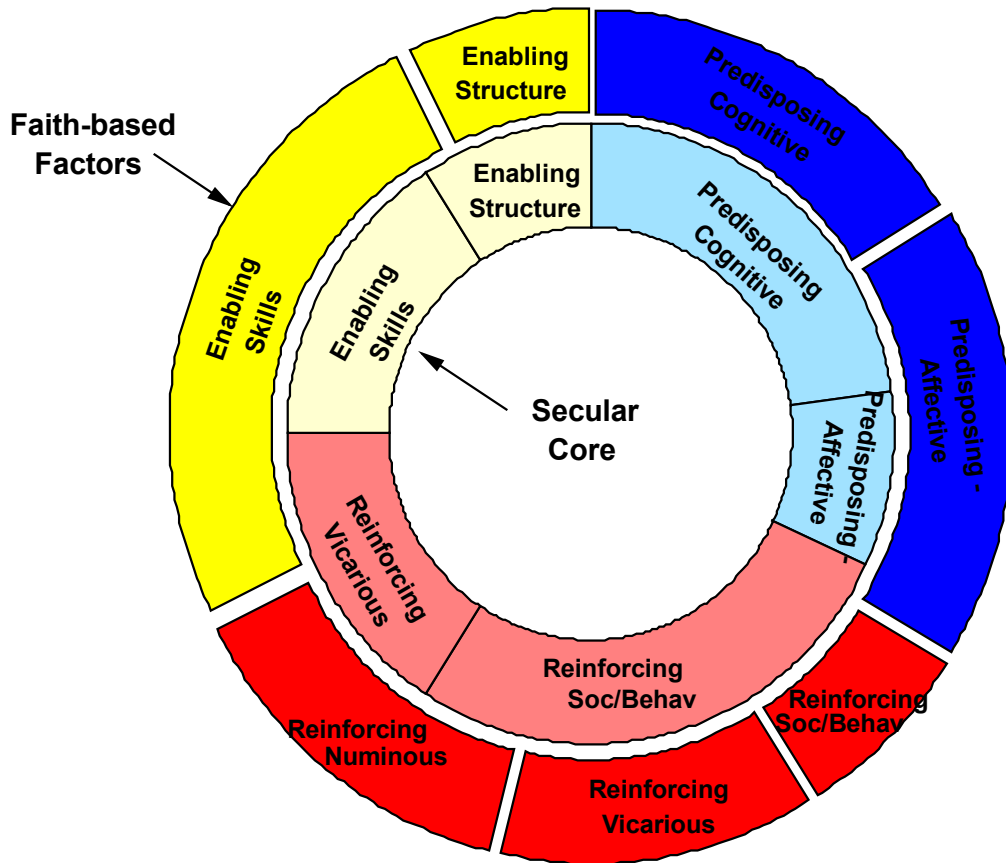
In conclusion, we know that faith-based movements and human services are not new, but have a history that spans decades and even centuries (Engs, 2000). Professionals and religious organizations will continue to do what they’ve always done. But by linking research and theory to practice, they now have the potential to advance the field by doing it more effectively—based upon evidence and not just faith.

Table 1 The Relationship between Religion and Spirituality Theories & the PRECEED Phase of Intervention

	Predisposing Factors		Enabling Factors		Reinforcing Factors	
	Cognitive	Affective	Individual skills	Structural	social/behav.	Numinous
PRECEED (Green & Kreuter, 1999)	knowledge, beliefs (or doubt), values, attitudes, and behavioral intention	self confidence a sense of self-efficacy	Existing skills Essential skills	access or impediments such as location, organizational culture and norms, symbols, rituals, policies, and the extent to which the context supports, models and rewards health promoting skills.	feedback, recognition, rewards, or from punishment family, friends, teachers, leaders, clergy cultural changes	vicarious reinforcement via esteemed other
Religious Involvement (Levin, 1989; Chatters, Levin & Taylor, 1992)	attitudes & beliefs	self perceptions	attendance, prayer, devotion, lifestyle	Affiliation		
Spiritual Well-being (Hawks, 1995; Chapman, 1987; Reed, 1987)	Meaning Part of a divine plan Coherence	Connection to God Connection to Self	Divine collaboration, empowerment & coping	Connection to others	Connection to others	Connection to God
Functional Mechanism btwn. Religion & Health Chatters, 2000; Chatters, Levin & Ellison, 1998)	1) healthy beliefs, (e.g obedience, devotion) 2) Interpret event from God's perspective, 3) divine guidance 4) Primary appraisal/challenge as growth opportunity 5) social construction of meaning 6) Expectation, faith, hope & optimism	Positive Emotions such as 1) self esteem & inherent individual worth 2) sense of personal mastery 3) Cathartic expression of negative emotions 4) self-soothing from coping & managing emotions 5) Loving & supportive relations w/ divine other	1) Various coping skills 2) lifestyle of abstinence, moderation, or other risk reducing behavior is normative	1) tangible or informational social supports, 2) norms and culture of reciprocity and altruism	perceived emotional support	1) Identifying with figures in religious text 2) Prayers support of other people

Compass to Guide Faith-based Intervention Planning & Evaluation

Figure 1



Intercardinal Points & Degrees on the Intervention Planning Compass

PREDISPOSING FACTORS			
Cognitive		Affective	
Secular	Faith-based	Secular	Faith-based
Cognitive reframing	Interpret phenomenon through divine/ doctrinal perspective	Enhance self esteem and self worth	Use religion to enhance self esteem and self worth
Socially construct meaning through shared narratives	Socially construct meaning through shared narratives expressed in religious vernacular	Increase mastery & skills	Divine collaboration & empowerment; spiritual rituals or affirmations to increase mastery
Coping: Appraisal of event as growth challenge	Coping: Appraisal of event as spiritual growth challenge	Coping: to manage emotions	Coping: relying on prayer or numinous support to manage emotions
Expectation, hope, optimism	faith, expectation, hope, and optimism because of belief in a divine other	Opportunities for Catharsis of negative emotions	Catharsis of negative emotions expressed religious phrases
Restructure healthy beliefs	Doctrine used to restructure healthy beliefs	Sense of social support and acceptance	Sense of divine love, support and acceptance
View event as part of larger plan	View event as part of larger Divine plan	Positive Emotions: Gratitude, Forgiveness	Positive Emotions based on Divine connection: Praise, Thanksgiving, Forgiveness
Professional knowledge Local knowledge	Doctrine-based knowledge	Inoculate against stress/setbacks	Religious themes & metaphors to inoculate against stress/setbacks
Behavioral Intention to change	Religious commitment to change		
Other	Other	Other	Other

Table 2

REINFORCING FACTORS				
Behavioral		Vicarious		Numinous
Secular	Faith-based	Secular	Faith-based	
consequences of behavior		Identifying w/ esteemed individuals	Identifying w/ figures in religious text	Sense of divine approval
self-monitoring	prayer journal	group/peer support	Prayer support of other people	Sense of divine disapproval
unintended consequences	unintended consequences perceived as a spiritual experience (e.g., blessings, harmony, peace)	Testimonials	Testimonials of divine intervention	

Table 3

ENABLING FACTORS			
Individual Skills (existing and essential)		Structural Support/Barriers (cultural context, location)	
Secular	Faith-based	Secular	Faith-based
Attendance	Attendance @ Religious Svcs.	tangible or informational social support	tangible or informational social support from congregants or clergy
	Prayer	norms of reciprocity and/or altruism	
Reading program materials	Reading Devotional/Relig. Materials;	organizational affiliation; member or non-member	member or non-member of hosting religious organization, denomination or congregation
	Situational Coping: Divine Collab. Or Empowerment;	use of symbols	use of religious symbols
fear or information induced lifestyle changes and norms	Faith-induced lifestyle changes and norms (e.g. abstinence, moderation or risk reducing behavior);	rituals	religious rituals
Maladaptive/Deferring Coping	Maladaptive/Deferring Coping: Waiting on God	modeling behavior w/in group or organization.	Members of religious organization model behavior w/in group or organization.
		supportive policies	
		exogenous institution indigenous community org	local religious org

Table 4

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