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Wounded Healers: Job Termination in FAITH COMMUNITY NURSING

ABSTRACT: *Research regarding faith community nursing termination is scarce. Ziebarth (2018) surveyed faith community nurses (FCNs) who had experienced termination of their position. This article explores FCN feelings related to termination and provides an evidence-based practice component to translate the research into practice. Given that FCNs engage in deep relationships with clients, their feelings following termination express grief and lack of support. Support strategies as well as preemptive strategies that may be useful to prevent loss of an FCN position or ministry are presented.*

KEY WORDS: *faith community nursing, grief, job termination, translational research*

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Loss of job for faith community nurses (FCNs) has been anecdotally relayed by FCNs for many years while research on termination of FCNs has been nonexistent. In the only published article examining FCN termination, Ziebarth (2018) explored FCNs' voluntary and involuntary termination through a national survey. Questions were asked pertaining to why termination occurred, resources used during termination, post-termination behaviors, and feelings related to termination. Findings were reported in Ziebarth's 2018 publication; however, respondents' feelings in relation to termination were not discussed. The purpose of this article is to further explore FCN feelings following termination as reported in a national survey and to incorporate an evidence-based practice translation of this research into FCN practice.

FAITH COMMUNITY NURSING: A UNIQUE SERVICE

With increased knowledge of faith community nursing as a specialty, a fuller understanding of the context in which termination of FCNs occurs is possible. All nursing specialties practice under the legal authority of each state's nurse practice acts and policies. In addition, all specialties are guided by the general *Nursing: Scope and Standards of Practice* (American Nurses Association [ANA], 2016), and by individualized specialty scope and standards of practice. Faith community nursing is guided by the *Faith Community Nursing Scope and Standards of Practice* which states that,

> Faith community nursing is a specialized practice of professional nursing that focuses on the intentional care of the spirit as the promotion of whole-person health and the prevention or minimization of illness within the context of a faith community and the wider community. (ANA & Health Ministries Association [HMA], 2017, p. 1)

Two well-noted theoretical definitions of faith community nursing are

> 1. Care that supports and facilitates physical functioning; psychological functioning and lifestyle change, with particular emphasis on coping assistance and spiritual care; protection against harm; the family unit; effective use of the health system; and health of the congregation and community. (Solari-Twadell & Hackbarth, 2010, p. 74)
>
> 2. A method of health care delivery that is centered in a relationship between the nurse and client (person, family, group, or community). The relationship occurs in an iterative motion over time when the client seeks or is targeted for wholistic health care with the goal of optimal wholistic health functioning. Faith integrating is a continuous occurring attribute. Health promoting, disease managing, coordinating, empowering and accessing health care are other essential attributes. All essential attributes occur with intentionality in a faith community, home, health institution and other community settings with fluidity as part of a community, national, or global health initiative. (Ziebarth, 2014, p. 1829)

Although professional nursing uses nursing interventions and the

Nursing Interventions Classification system (Butcher et al., 2018) to describe practice, in the early faith community nursing movement, *role functions* were frequently used. Initially, the role was conceptualized into five functions (Solari-Twadell & Westberg, 1991), and later seven functions (Jacobs, 2019; Solari-Twadell & McDermott, 1999). The seven roles include integrator of faith and health, personal health advisor, health educator, trainer of volunteers, developer of support groups, referral agent, and health advocate. It was subsequently recommended that the seven roles be regarded as nursing interventions in describing what FCNs do (Solari-Twadell & Hackbarth, 2010).

Based on a literature review of 124 articles, Ziebarth (2014) found that FCNs perform additional routine nursing interventions. These interventions include (a) intentional spiritual care, spiritual leadership/practices, and integration of health and faith; (b) coordination, implementation, and sustentation of ongoing activities; (c) utilization and application of survey results; (d) training and utilization of volunteers; (e) multidisciplinary and interdisciplinary resourcing and referring; and (f) the goal of wholistic health functioning. However the practice is described, this nursing specialty is unique in that the FCN is a registered nurse who has additional training to work in/with a faith community and to provide spiritual care.

FCNs provide a unique service. The Joint Commission (2010) states that patients have specific characteristics and nonclinical needs that can affect the way they view, receive, and participate in healthcare. Patients who have services rendered by an FCN may experience a range of assessments and interventions that promote an adaptive process of attaining or maintaining wholistic health functioning (Solari-Twadell & Hackbarth, 2010; Wolf et al., 2008; Ziebarth, 2015, 2016).

TERMINATION IN FAITH COMMUNITY NURSING

Voluntary termination is when employees decide to leave a job of their own accord because of a change in personal circumstances, dissatisfaction with working conditions, or the search for a better job. Voluntary termination can occur when FCNs are not successful in assuming the FCN role. Ziebarth and Miller (2010) found that certain role-transition interventions had an impact on successfully assuming an FCN role. Some role-transition deterrents were insufficient time to practice, inadequate knowledge, lack of support, and lack of program value perceived by the faith community. Some positive perceptions of role-transition support were peer support groups, orientation, mentors or role models, and continuing education.

Involuntary termination is when an employee is asked to leave a job and most often occurs in faith community nursing when a program is eliminated. Programs are eliminated at both

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hospitals and faith communities for different reasons. Many hospitals fund faith community nursing programs in a missional environment. The FCN programs are a non-revenue-producing department and are "most at-risk for elimination when margin is threatened" (Ziebarth, 2015, p. 89). Revenue-producing activities are the core business of most hospitals. Margin means having excess money to do missional activities. Unless additional altruistic reasons exist, most hospitals support faith community nursing through *Community Benefit* status where nonprofit hospitals obtain tax-exempt status by offering initiatives to improve health in the communities they serve (Community Benefit Connect, 2020). If revenue-producing activities ineffectively support non-revenue-producing programs or if priorities change, the hospital may eliminate faith community nursing activities.

In faith communities, most think the core purpose is interpreting Scripture, worship, making disciples, and doing good deeds, not promoting health or preventing illness. Chase-Ziolek (2015) argued that the Church needs to reclaim its biblical and historic foundations for ministries of health, healing, and wholeness through health ministry. Many faith communities support FCN programs for altruistic reasons linked to Scripture, but unless there is economic support, an FCN program may be at risk for closure.

Related to FCN termination, faith community leadership termination is the termination of pastors and other faith community leaders. Three earlier studies (Blackmon, 2011; Fuller et al., 2003; Krejcir, 2007) identified stress, low income, low self-esteem, isolation, conflict, and lack of skills as contributing to faith community leadership termination. The studies also revealed environmental stressors exist unique to faith communities. As FCNs work in or with faith communities and are perceived as leaders, understanding aspects of FCN termination is important to supporting practice and retaining FCNs and their leadership in the faith community.

Table 1. Reasons for Faith Community Nurse Termination (Ziebarth, 2018)

Reason for termination	Number of terminated FCNs giving this reason	Percent of the terminated FCNs
Change in leadership	25	29.11%
Not a strategic priority	23	26.58%
Organization restructuring	22	25.32%
Not a financial priority to hospital/ healthcare organization	21	24.05%
Not a financial priority to the faith community	19	21.52%
Personal reasons	18	20.25%
FCN program startup was grant-driven and funds ran out	10	11.39%
Retirement	10	11.39%
Health-related	8	8.86%
Not the best fit	7	7.59%

Write-in comments:
- Not paid enough to cover childcare expenses
- Pastors unwilling to let go of duties
- Declining membership and available funds
- Was not accepted by pastor
- Too stressful to work with the church leadership
- …congregation wants to move in a different direction
- …resigned. Pastor did not fully support what I was doing
- …wanted a younger nurse
- …came in response to numerous changes including personnel changes
- Mission drift
- Loss of husband
- It was a non-revenue-generating department; keeping patients out of the system was counter-productive
- Reported abuse and lost my job
- New pastor removed all leaders and office personnel
- Moved away
- Personality conflict with pastor
- The clergy appointment became detrimental to the faith community
- Church closed
- Hospital systems not interested in supporting this [the FCN ministry]

Note. The FCNs could respond to more than 1 reason; thus, the total number of all responses is greater than $n = 87$ and greater than 100%.
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FCN TERMINATION SURVEY

A survey exploring FCN termination seeking a representative sample of the larger FCN population in the United States was conducted in 2017. Survey Monkey online was used to collect data. A link to the survey was available through the regularly published Westberg Institute e-newsletter. A total of 264 FCNs responded to the survey's first question, "Were you ever voluntarily or involuntarily terminated from your position as a faith community nurse or faith community nurse coordinator?" Eighty-seven ($n = 87$, 33%) of the FCNs self-identified as having experienced termination and answered the remaining questions. Out of the 87 who were terminated, 23.69% ($n = 59$) were voluntarily or involuntarily terminated as an FCN and 12.73% ($n = 28$) as an FCN coordinator; 46.58% were in unpaid FCN positions and 53.42% were in paid positions. Table 1 relays responses to the question, "What was the reason(s) for the termination?"

Table 2 shows responses to the next three survey questions regarding resources used after termination (Ziebarth, 2018).

Many of the FCNs returned to the role in another setting. Those who did not return relayed continuing aspects of FCN practice such as doing grief support groups and grief counseling, organizing blood drives, maintaining a bulletin board in the faith community, and serving on the advisory board for their local FCN organization or on the board of the state-led FCN organization.

Issues unique to FCN termination found in Ziebarth's study (2018) were (a) the high percentage of involuntary FCN terminations due to program closure in both hospitals and faith communities; (b) the search for both a new job and a new faith community home after involuntary termination; (c) the high percentage of FCNs returning to unpaid FCN positions after termination; and (d) the lack of resources for FCNs experiencing termination (Ziebarth, 2018).

Table 2. Resources Utilized, Resources Recommended, and Return to FCN Practice after Termination (n = 87) (Ziebarth, 2018)

If resources were utilized after FCN termination, what were they?	What resources would you recommend at the time of the termination or would be helpful after termination?	Did you return to FCN practice after termination? If so, what role?
Family and friends 59.38% (52 FCNs)	A tool specific for FCNs experiencing termination and transition 64.52% (56 FCNs)	FCN non-paid 48.44% (42 FCNs)
Spiritual in nature 59.38% (52 FCNs)	A list of resources for job transition and "Grief and Loss" 46.77% (41 FCNs)	FCN paid 32.81% (26 FCNs)
Peers 46.88% (41 FCNs)	A conference or workshop 40.32% (35 FCNs)	FCN educator 20.31% (18 FCNs)
Professional therapist 28.13% (24 FCNs)	A retreat focused on FCN termination and transition 32.26% (28 FCNs)	FCN coordinator/manager 17.19% (15 FCNs)
Books and literature 28.13% (24 FCNs)	Support group 29.03% (25 FCNs)	FCN consultant 15.63% (14 FCNs)
Counseling: Yes 32.61% (28 FCNs) No 67.38% (57 FCNs)		FCN scholar (additional education) 7.81% (7 FCNs)
		FCN administration (FCN job, not direct care provider) 4.69% (4 FCNs)
		FCN researcher 3.13% (3 FCNs)

Note. The FCNs could respond to more than 1 reason; thus, the total number of all responses is greater than n = 87 and greater than 100%.
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FEELINGS RELATED TO TERMINATION

In an effort to understand the experience of FCN termination, Ziebarth (2018) asked, "When you lost your position as a FCN, describe your feelings." The FCNs who experienced involuntary termination relayed anger, sadness, devastation, and mourning the lost position. The responses in Table 3 illustrate the intense pain of the FCNs. The responses were divided into five categories of *normal grief*: denial, anger, bargaining, depression, and acceptance, as first proposed by Elisabeth Kübler-Ross (1969).

Some responses to the feelings question suggested voluntary termination. Although sadness was relayed, other feelings were gratitude and acceptance:

- "I retired and still take calls when the two who replaced me are not available."
- "It was my choice." "I was getting married and moving out of state."
- "I didn't think about the situation very much, because I had already been transitioning out of my usual role in the ministry so that I could go back to school."
- "I retired, and another person is serving in the coordinator position."
- "I was already in discussion with another group to become an educational partner and begin teaching at the new organization."
- "Grateful for the blessings of being an FCN and happy to retire."
- "Sad that I had to make the change but was happy to be a stay-at-home mom."
- "I was able to find another person to take my position at the parish."
- "I retired to spend time with my husband who was having health problems."
- "Acceptance, as it was mutually agreed upon."

TRANSLATION OF RESEARCH INTO PRACTICE

Research produces new findings, results, and outcomes, contributing to the body of knowledge from which nursing draws. Research has significant value; however, translation of research into practice when utilized to improve nursing practice, is where the true worth of research lies. The Westberg Institute's Position Statement (Knighten, 2019, p. 1) states "the faith community nurse supports, applies, and engages in evidence-based practice."

When FCNs terminate their positions, either voluntarily or involuntarily, and/or FCN and health ministry programs are eliminated, deep losses are felt. The primary role of the FCN—intentional care of the spirit in a whole-person context: caring for the mind, body, and spirit of individuals, congregations, and communities—is a very intimate role, so the impact of loss is extreme. Respondents

TABLE 3. When You Lost Your Position as a Faith Community Nurse, Describe Your Feelings

Denial	Anger	Bargaining
• Did not understand • Surprise • Disbelief • Cannot understand why • Made no sense to me • Couldn't believe the decision	• Hurt • Disappointed (4) • Betrayed (2) • Shocked, angry (2) • Questioning, and doubting my calling • Shocked (2) • Very hurt and betrayed • Angry (4) • Frustrated (3) • Angry and disappointed • Terrible/devastated (2) • Angry as I had the position for years with no complaints • Hurt and insulted • Bullied. Humiliated. Defeated. • Abandoned • Ambushed and verbally abused • Given an impossible choice… • Sadness and anger (3) • Disappointed that leadership did not see the ministry as something worth the money • Resentment toward the new pastor who made the decision • Disappointed that academic hospital leadership would find little value • So frustrated that hospital leadership didn't see need • Angry and sad at the same time. I am member of the congregation that I served • Angry and disgusted with the hypocritical stance • So many members are angry and will leave • Shocked that a pastor and an elder did this …tried to cover it up • Where was the church body? How can professed Christians allow such an injustice? • Abandoned… all my Kingdom work was for nothing • Felt misunderstood and unsupported	• Health council & parishioners were very upset as well. Wrote many letters • Left hoping to return when the leadership changed • Had multiple churches that I supported …monthly support groups… community programs were well attended • Belonged to several community boards… Taught FCN foundation courses… Mentored nursing students • Although I tried to educate hospital leadership to the importance of FCN …they closed the program saying they could not afford to keep it open • Knew in my heart I am one of the best parish nurses • Began to question my own ethics and how I had managed to work in a church with a philosophy and theology so different from my own • What did I do wrong? What could I have done to prevent the termination of the program? • Why did it happen? What went wrong? Did I do something wrong? Is it my fault? Could I have changed the situation? • Thought the hospital/leaders were blind to community needs

Note. Answers are shortened to de-identify the FCNs.

relayed that it is as if "a hole is ripped in the heart and soul of the church." Hinton (2016) describes the practice of faith community nursing as not simply a job, but a calling and a ministry. Losing any job is painful, but the loss of one's ministry can shake one to the core.

Although FCNs who were terminated involuntarily described negative feelings (Table 3), FCNs who leave voluntarily may also experience mourning. In his classic text, Noer (1993) posits that those who are left behind after a position has been eliminated or vacated experience the same feelings as those who left—anger, fear, sadness, hurt, and guilt—with alarmingly more intensity than the person who left.

Many FCNs shared caring for their congregation's wounds while trying to look after themselves in their wounded state. Theologian Henri Nouwen (1979) describes wounded healers as individuals who must attend to their own wounds while simultaneously healing the wounds of others. Putting Nouwen's observations in the context of the FCN who vacates a position, a paradox exists in which the FCN may feel compelled to care for the congregation's wounds while trying to look after himself or herself in the wounded state. This perceived need may result in moral distress.

Dirksen (1993) identified that involuntarily imposed work cessation is a very stressful event that represents the loss of a central role and life function. In addition, involuntary termination, or the antipation of termination, can lead to pyschological and physical health consequences and maladaptive

Depression	Acceptance
Worried • Sad and concerned about the hundreds of elderly…who would no longer get services • Felt like I couldn't do what God was calling me to do • Worried about the lack of services • What will happen to some of my programs? • Now am very sad and concerned for the members of the congregation still needing help • Don't want to be the cause of dissension in the church (people leaving because of my termination) • Worried about those whose care I was involved with • Concerned for the future of the FCN program **Loss and sadness** • My world was black, my belief in God wavered, I felt empty, and life had no meaning or purpose • The Scriptures felt like empty words on the page • Had to leave the church I'd worshipped in for 25 years and I grieved that loss • What will my role be going forward? • Very lost. I thought, where do I go from here? • Saddened for the Body of Christ • Felt lost in my profession • Frustrated and unclear on how to proceed • Concerned about the future • Felt like my life was on hold • Did not know how to explain it to others • Deep loss • Very disappointed • Sadness and frustration (2) • Sad and discouraged • Sadness (2) • Depressed (3) • Never lost a job in 43 years of nursing • Devastated, as I'd never lost a job • Very sad; had been an FCN in the church for 10+ years • Sad to lose the position • Sad, taken advantage of, in grief; I mourned • Felt the deepest spiritual pain I had ever in my life • Lost, depressed, devalued, tossed out like an old rag • Maybe I heard the call from God wrong **Not wanted/failure** • Unwanted • Not valued • Unimportant • Ashamed, guilty because they refused to let me transition to FCN position instead of coordinator • Felt like a failure • How could I have done a better job? **Fear** • Scared—I support myself and had put together several FCN jobs to equal a full-time position • I have been laid off 4 times • That I would never accept work in a church setting again	• My family and I are transitioning and looking for a new church (3) • I left the church • Since it was my home church, needed to find a new home church since the congregation would always think of me as their FCN whether I was official or not and that proved true • Sad to say goodbye but felt good to have made a difference in lives I served • Confident because I knew God had other plans • God had other opportunities for me • Sad, but knew it was okay • Ultimately felt relief • I grieved the loss of the position and moved on • Had mixed emotions about losing one of the best jobs I ever had • Did not feel that it was something the church could prevent because of the declining monetary giving • Saw it coming about 6 months prior, so I began making plans • Was not unexpected, as hospital had been bought by a secular for-profit group • I continued with my other two churches • Guess I will retire and volunteer in my own church • I needed to defer the grieving and get practical as I had a family depending upon my wages • Overwhelmed as I had 2 weeks to find a new paying position • I find myself counseling people around my termination • Can I find another job? Where? • Once an FCN, always an FCN • Was too sick…to fret over the dismissal. I knew God would guide me on the path. When a door closed, a window flew open! • I'll always be an FCN. I'll just begin to serve in different ways and possibly in different faith communities • Knew I could continue to participate as a volunteer in the FCN program. That was helpful, as I still stayed connected • Time to discern what & where I was to go • Not surprised

behavioral responses that may manifest immediately or over time. The effect of prolonged anticipation of job loss has been found to be associated with increased psychosomatic complaints, resentment toward both the organization and the world in general, and a diminished sense of security in the future (Dirksen, 1993). Although it is possible for the recently terminated FCN to perceive job loss as positive, it is far more likely that it may be the most stressful life event ever experienced.

Farley (2006) described a survey of mental health professionals who experienced job layoffs. Their responses were similar to those of FCNs, including anger, shock, disbelief, and sadness that progressed to depression, anxiety, and feelings of being betrayed and devalued. The two primary coping mechanisms expressed were processing these feelings by talking to others who were laid-off and focusing on job-seeking (Farley, 2006).

Bland (2015) reviewed global trends and risk factors associated with job loss in the United States, indicating that most Americans perceive decreased employment stability and job displacement as common in the labor market. Bland found that worker displacement is associated with subsequent unemployment, long-term earnings loss, lower job quality, decline in physical and psychological well-being, loss of psychosocial assets, social withdrawal, family disruption, and lower levels of children's well-being. The sequelae reach well beyond the individual to touch the family, impact

the social network, and bleed into the community.

In discussing the FCN termination survey, Solari-Twadell and Ziebarth (2020) identified that terminations occurred as a result of leadership change, organizational restructuring, and the role not being considered a strategic or financial priority. Each time there is a new pastor, change in reporting structure, financial hardship, or personal crisis, the FCN position may be at risk for elimination.

PREVENTING TERMINATION

Preemptive strategies may be useful to prevent loss of the FCN position or ministry (Solari-Twadell & Ziebarth, 2020). For example, FCNs should meet with new pastors to educate them on what a health ministry is and what the role of the FCN entails. Bagley (2011) examined the opportunities and barriers of FCN practice implementation, identifying that the majority of pastors would support a health ministry program to address health needs in their congregations. Presenting outcomes achieved to sustain health and wellness in the congregation and community is important. Connecting health ministry to evangelization through providing service to God's people integrates health and faith concepts, aligning with the faith community's mission. The FCN may ask for support, offer assistance, and demonstrate collaboration. It is imperative that both the faith leader and the FCN understand her/his individual roles and how the roles are enhanced by collaboration, discussing what skills and knowledge each contributes. The nurse should be aware the faith leader may not have worked with a faith community nursing program before and might feel threatened (Catholic Health Association of the United States, 2016).

Another important strategy is to create an environment and infrastructure where the health ministry can be financially self-sustaining. This reduces the burden on the church's general budget and allows allocation of resources when church finances may be strapped.

Succession planning is important when the FCN anticipates personal reasons for why the role may become vacant. Planning involves praying for guidance and discernment, identifying and developing a successor, and preparing the congregation using a change/transition model. A well-developed health cabinet may carry forward health ministry goals while the search for a new FCN occurs.

RECOMMENDATIONS FOLLOWING TERMINATION

In Ziebarth's 2018 survey, FCNs who were terminated self-identified interventions used, actions taken, and resources that were or would have been helpful. These included friends and family, peers, spiritual resources, professional therapists, and books/literature when in transition. The FCNs' recommendations are listed in Table 2.

Respondents relayed that it is as if a hole is ripped in the heart and soul of the church.

It is clear that resources need to be developed to assist FCNs in transition after termination as a significant gap exists between what is needed and what is available. FCNs may use their professional association for support. It also could be helpful to use a *transition model*. Transition is a three-prong psychological reorientation process used as people come to terms with a change, focusing on letting go of and grieving for what was while anticipating a new beginning or what will be. A transition model can impact the potentially chaotic, negative, anxious period between letting go of the termination and old position (called the *neutral zone*) into a time of creativity, innovation, and hope as a new beginning is anticipated (Bridges & Bridges, 2017).

The Model for Healthy Living (Model) is an evidence-based framework used to assess wholistic wellness and the interconnectedness of body and spirit (Church Health, n.d.). The Model recognizes the particular challenges of balancing life while fulfilling a call to ministry against the backdrop of vocation (Church Health Reader, 2018). As the FCN works through the termination process, the seven dimensions of wellness may be used to guide questions, reflect on healing Scriptures, and create actionable goals to regain whole person health and wellness. One FCN's experience following termination involved seeking spiritual direction for help identifying her ministry calling.

Finally, Hinton (2016) provides comfort in the life-altering situation that is termination of employment:

- Our job is not where our value lies; value is in God's eyes and has nothing to do with the ministry.
- God's plan is bigger than ours and he is at work no matter how painful the situation.
- Our emotions and feelings are only one perception of the situation; owning our emotions allows God to help us learn and grow spiritually.
- Take the high road. Pray, conduct self-examination, speak to someone for spiritual support and direction; do not take responsibility for others' choices, behaviors, or actions.
- Pray for those who persecute us and cause pain and suffering (Matthew 5:44). Prayer changes our perspective and removes others' power to hurt us.
- Prepare for the next step God has chosen specifically for us. He is already at work preparing our future.

Losing an FCN position or having one's ministry eliminated is a stressful, painful life-altering event. There is hope in God's plan for us, that our gift of service will be used as we lean into him and use available resources.

American Nurses Association. (2016). *Nursing: Scope and standards of practice,* (3rd ed.).

American Nurses Association, & Health Ministries Association. (2017). *Faith community nursing: Scope and standards of practice,* (3rd ed.).

Bagley, C. A. (2011). *Parish nurse practice implementation: Opportunities and barriers* (Publication No. 3466281). [Doctoral dissertation, Walden University.] ProQuest Dissertations Publishing.

Blackmon, J. D. (2011). *Awakening sleeping beauty*. Xulon Press.

Bland, J. E. (2015). The far-reaching impact of job loss and unemployment. *Annual Review of Sociology, 41*, 239–375. https://doi.org/10.1146/annurev-soc-071913-043237

Bridges, W., & Bridges, S. (2017). *Managing transitions: Making the most of change, 25th anniversary edition*. Perseus.

Butcher, H. K., Bulechek, G. M., Dochterman, J. M., & Wagner, C. M. (Eds.). (2018). *Nursing Interventions Classification (NIC)* (7th ed.). Elsevier.

Catholic Health Association of the United States. (2016). *Improving the lives of older adults through community partnerships: Healing body, mind and spirit*. https://www.chausa.org/docs/default-source/eldercare/improving-the-lives-of-older-adults-through-faith-community-partnerships_final-oct-192016.pdf?sfvrsn=0

Chase-Ziolek, M. (2015). (Re)Claiming the Church's role in promoting health: A practical framework. *Journal of Christian Nursing, 32*(2), 100–107. https://doi.org/10.1097/CNJ.0000000000000153

Church Health. (n.d.). *The Model for Healthy Living for Health Ministry*. *https://store.churchhealth.org/products/the-model-for-healthy-living-for-health-ministry-digital-download?_pos=3&_sid=ffe62662f&_ss=r*

Church Health Reader. (2018). The Model for Healthy Living for Clergy: Self-assessment, reflection and goals. *Church Health Reader, 8*(4), 7–20.

Community Benefit Connect. (2020). *What is community benefit?* https://www.communitybenefitconnect.org/about-us/about_what-is/

Dirksen, M. E. (1993). Unemployment: More than the loss of a job. *American Association of Occupational Health Nurses Journal, 42*(10), 468–476. https://doi.org/10.1177/216507999404201002

Farley, J. E. (2006). Responses of mental health professionals to lay-offs. *Psychiatric Services, 57*(5), 624–627. https://doi.org/10.1176/ps.42.6.624

Fuller, H. L., Campbell, C., Celio, M. B., Harvey, J., Immerwahr, J., & Winger, A. (2003). *An impossible job? The view from the urban superintendent's chair*. The Wallace Foundation. https://eric.ed.gov/?id=ED480673

Hinton, S. T. (Spring 2016). How could God let this happen? When loss of a position causes spiritual woundedness. *Perspectives, 15*(1).

Jacobs, S. (Ed.). (2019). *Foundations of faith community nursing, participant guide 2019 revision*. Church Health.

Knighten, M. L. (2019). *Role of the faith community nurse in evidence-based practice [Position Statement]*. Westberg Institute for Faith Community Nursing.

Krejcir, R. J. (2007). *Statistics on pastors*. Life Christian Counseling Network. http://www.safeharborofsmd.com/pastors/Statistics%20on%20Pastors.pdf

Kübler-Ross, E. (1969). *On death and dying*. Scribner.

Noer, D. M. (1993). *Healing the wounds: Overcoming the trauma of layoffs and revitalizing downsized organizations*. Jossey-Bass.

Nouwen, H. J. M. (1979). *The wounded healer*. Image Books.

Solari-Twadell, P. A., & Hackbarth, D. P. (2010). Evidence for a new paradigm of the ministry of parish nursing practice using the nursing intervention classification system. *Nursing Outlook*, *58*(2), 69–75. https://doi.org/10.1016/j.outlook.2009.09.003

Solari-Twadell, P. A., & McDermott, M. A. (Eds.). (1999). *Parish nursing: Promoting whole person health within faith communities*. Sage.

Solari-Twadell, P. A., & Westberg, G. (1991). Body, mind, and soul. *Health Progress*, 24–28.

Solari-Twadell, P. A., & Ziebarth, D. J. (2020). Long-term sustainability of faith community nursing programs. In P. A. Solari-Twadell & D. Ziebarth (Eds.), *Faith community nursing: An international specialty practice changing the understanding of health* (pp. 275–286). Springer.

The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient and family centered care: A roadmap for hospitals*. Author.

Wolf, D. M., Lehman, L., Quinlin, R., Zullo, T., & Hoffman, L. (2008). Effect of patient-centered care on patient satisfaction and quality of care. *Journal of Nursing Care Quality, 23*(4), 316–321. https://doi.org/10.1097/01.NCQ.0000336672.02725.a5

Ziebarth, D. (2014). Evolutionary conceptual analysis: Faith community nursing. *Journal of Religion and Health*, *53*(6), 1817–1835. https://doi.org/10.1007/s10943-014-9918-z

Ziebarth, D. (2015). Why a faith community nurse program? A five-finger response. *Journal of Christian Nursing, 32*(2), 88–93. https://doi.org/10.1097/CNJ.0000000000000159

Ziebarth, D. (2016). Wholistic health care: Evolutionary conceptual analysis. *Journal of Religion and Health*, *55*(5), 1800–1823. https://doi.org/10.1007/s10943-016-0199-6

Ziebarth, D. (2018). Job termination survey: Faith community nursing. *International Journal of Faith Community Nursing*, *4*(1), article 4. https://digitalcommons.wku.edu/ijfcn/vol4/iss1/4

Ziebarth, D., & Miller, C. (2010). Exploring parish nurses' perceptions of parish nurse training. *Journal of Continuing Education in Nursing*, *41*(6), 273–280. https://doi.org/10.3928/00220124-20100401-01