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COVID-19 Caregiving Strategies, Quality of Life, and Stress Among Faith Community Nurses and Faith Leaders in Appalachia

ABSTRACT: *Faith community nurses (FCNs), pastors, and priests faced many challenges from the COVID-19 pandemic, serving as frontline sources of support for congregants. The aim of this study was to identify the most common care strategies used during the COVID-19 pandemic and examine professional quality of life, perceived stress, and associated factors in faith leaders and FCNs in rural Appalachia. Using a cross-sectional, descriptive survey design, high compassion satisfaction was reported along with compassion fatigue as caregiving moved to virtual platforms, suggesting the need for greater support.*

KEY WORDS: *Appalachia, burnout, compassion satisfaction, COVID-19, faith community nurses, nursing, Perceived Stress Scale, Professional Quality of Life Scale (ProQOL)*

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The COVID-19 pandemic, an unprecedented health crisis, severely disrupted life. In the United States, the Centers for Disease Control and Prevention (2020) launched social distancing guidelines to safeguard healthcare providers and the public. Following the initial World Health Organization (WHO, 2020a) recommendations to minimize nonurgent hospital-based care and appointments, many preventive programs and noncritical care were canceled due to shortages of medications, providers, and essential medical supplies (i.e., personal protection equipment). According to a survey across 155 countries, 53% disrupted services for hypertension treatment, 49% for the treatment of diabetes and its complications, 42% for cancer treatment, and 31% for cardiovascular care (WHO, 2020b). During these unprecedented times of COVID-19, the United States and other countries adopted telemedicine (remote treatment via telecommunication) to replace in-person clinic visits. Telecommunication helped support ongoing visitations through phone, Facebook, FaceTime, online video conferencing (Zoom, Skype), and other sources (Lee et al., 2020).

COVID-19 AND RURAL COMMUNITIES

Rural communities across America were deeply impacted by the COVID-19 pandemic and restrictions. The Appalachian region, which runs from the state of New York through West Virginia and as far south as Alabama, has both urban and rural communities. With mountainous geographic isolation and lack of trust in the healthcare system, rural Appalachians in West Virginia were already suffering extreme inequities in health and economic resources (Feltner et al., 2017). Diminished resources in rural parts of West Virginia further aggravated the disruption of health services caused by COVID-19 and social distancing (WHO, 2020a). However, strong positive cultural traditions of religiosity and a preference for social support from family members, neighbors, and church members assisted those in rural areas.

Faith community leaders, such as pastors and priests, and faith community nurses (FCNs) play significant roles in healthcare support in rural communities. Faith community nurses work to provide for the health-related needs and education of the congregation they serve. Support from FCNs might include a home visit, hospital visit, nursing home visit, or education and screening at faith community meeting locations. Researchers report that the spiritual care provided by FCNs helps alleviate family anxiety during life and death transitions as well as support community members' decision-making for medical treatment (American Association of Critical-Care Nurses, 2017; Anaebere & DeLilly, 2012; Yeaworth & Sailors, 2014). Faith community nurses have a close alliance with members of the congregation and often are requested to support families managing serious chronic illnesses (Lentz, 2018; Ziebarth, 2014).

Within their roles, faith community leaders (leaders) and FCNs had the overwhelming task of assessing community members' physical and emotional demands during the social distancing and stay-at-home orders. This created a stressful experience for the leaders and FCNs as they reviewed the traumatic effects of the COVID-19 pandemic on their communities. Stressful life situations impacted professional quality of life and can lead to burnout (Powell, 2020).

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EXPLORING CARE & COVID IMPACT ON FAITH LEADERSHIP
Study Purpose

The purpose of this study was to (a) identify the most common care strategies faith leaders and FCNs used during the beginning of the COVID-19 pandemic (March 2020–August 2020) and (b) examine the relationships between the professional quality of life, perceived stress, and associated factors in the leaders and FCNs. Reed's *Theory of Self-Transcendence* was used as a framework to guide development of the study (Abu Khait et al., 2020; Reed, 2018). The theory facilitates turning difficulties and struggles in life into meaningful systems of support. In the theory, commitment to care is defined as assuming a burden to create a place of refuge and occurs when a person assumes the caregiver's role to create a place of comfort and safety for a patient. Framing caregiver practices as purposeful interventions leading to intended outcomes, such as promoting well-being, provides support for the client. The work of faith leaders and FCNs aligns with this framework (Fiske, 2019).

Design, Settings, Sample, and Instruments

A cross-sectional, descriptive survey design was used for this study. The study was approved by the West Virginia University (WVU) Institutional Review Board. The survey was administered by clinical and research nursing faculty at WVU in May 2020. Participants were recruited using a convenience sampling method. Facebook groups designated for faith community leaders and FCNs were used to provide information about the study and encourage interested leaders and FCNs to complete the survey. Participants who volunteered completed an anonymous electronic survey via a secured Health Science Center URL link.

The study survey consisted of demographic questions, the Professional Quality of Life (ProQOL) Scale,

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the Perceived Stress Scale (PSS), and two open-ended questions. The survey took about 20 minutes for participants to complete.

The ProQOL is a 30-item, 5-point Likert-type scale (Stamm, 2010) with two subscales: Compassion Satisfaction and Compassion Fatigue. The Compassion Satisfaction subscale measures satisfaction derived from being able to do a job well. A higher score indicates better professional satisfaction from the job.

The Compassion Fatigue subscale has two components: Burnout and Traumatic Stress. The Burnout subscale measures feelings of hopelessness and difficulties in dealing with work or in doing the job effectively. Higher scores indicate more burnout on the job. The Traumatic Stress subscale measures work-related secondary exposure to extremely stressful events. A higher

score indicates more stress. Each subscale has a standardized mean score of 50 (Stamm, 2010).

The PSS is a unidimensional 14-item, 5-point Likert-type scale (Cohen et al., 1983; Cohen & Williamson, 1988). The scale measures the degree to which situations in a person's life were perceived as stressful in the last month, ranging from 0 (*never*) to 4 (*very often*). The total score ranges from 0 to 56, where a higher score indicates higher perceived stress. The Center for Health Discovery and Well-Being (2018) categorized the scores into three levels: low stress (scores 0–18), moderate stress (scores 19–37), and high stress (scores 38–56).

Data Analysis

Data from the electronic survey were downloaded to IBM SPSS Statistics Version 26 (IBM, 2019) for

analysis. A bivariate linear regression analysis was performed for each of the three ProQOL subscales to assess the association of a single independent variable with each subscale. Variables with p values significant at 0.20 in bivariate analyses were included in the final multiple linear regression models (Kutner et al., 2004). G*Power v3.9.1.4 was used to compute the statistical power for multiple linear regression analysis (Faul et al., 2009). Based on the sample size ($N = 49$), assuming an α level ($\alpha = 0.05$) and effect size = 0.15 (moderate effect), with five predictors, power could reach 77%. With two predictors, the power could reach 84%.

STUDY RESULTS
Demographic and Work-Related Characteristics

Out of approximately 100 leaders and FCNs, 49 ($N = 49$) from 10 West Virginia counties completed the survey; 12 (24.5%) were FCNs and 37 (75.5%) were faith leaders. Demographic data included age, gender, type of faith community, years of experience in the faith community, rural or urban location, previous online experience, previous experience with distance technology and distance-based interaction, and sizes of the faith communities served (see Table 1). Among the faith leader participants, 26% held a Master of Divinity degree, 20% were ordained pastors, and 47% had been working as a faith leader for more than 20 years. Educational status of the FCNs was not assessed. Among the 12 FCN participants, nine (75%) had been working as a nurse for more than 20 years.

For both the leaders and FCNs, 65% worked full-time within the faith community setting and 35% part-time. Faith leaders tended to be in paid positions and the FCNs tended to be in unpaid positions. Participants reported performing various types of services for congregants prior to the pandemic, including home visits (20%), education (16%), nursing home visits (13%), hospital visits (19%), and other support upon request. During the pandemic, 60.4% ($n = 29$) reported increased distance-based interactions (e.g., consulting by telephone, answering email).

Table 1. Demographic and Work-Related Characteristics ($N = 49$)

Variable	Number (%)
Age (years)	
<50	15 (30.6)
≥50	34 (69.4)
Gender	
Male	24 (49.0)
Female	25 (51.0)
Employment/Job Status	
Full-time	32 (65.3)
Other	17 (34.7)
FCN or Faith Leader	
FCN (3 FCNs were also faith leaders)	12 (23.1)
Pastors/Faith Leaders	40 (76.9)
Having experience in distance technology prior to COVID-19	
Yes	42 (85.7)
No	7 (14.3)
Distance-based interaction during COVID-19 (missing one response)	
Increased	29 (60.4)
Other	19 (39.6)
Faith leader years of experience (Pastor or Priest)	
<10	9 (22.5)
≥10	31 (77.5)
Type of Faith Community	
Protestant	26 (53.1)
Catholic	19 (38.8)
Other	4 (8.1)
Urban or Rural Status (missing 5 responses)	
Rural	16 (36.4)
Urban	28 (63.6)
Faith Community Size (missing 3 responses)	
<100	22 (47.8)
101–300	11 (23.9)
>300	13 (28.3)

Table 2. Mean, Standard Deviation, and Proportions on Professional Quality of Life Subscales (ProQOL) and Perceived Stress Among Participants (*N* = 49)*

Scale or Subscale	M (SD)	Range	n (%)		
			Low	Moderate	High
Compassion Satisfaction (10 items)ᵃ	39.27 (6.69)	22–50	1 (2.1%)	26 (54.2%)	21 (43.7%)
Burnout (10 items)ᵃ	21.17 (5.91)	10–36	28 (58.3%)	20 (41.7%)	0
Traumatic Stress (10 items)ᵃ	21.69 (7.71)	11–43	30 (62.5%)	16 (33.3%)	2 (4.2%)
Perceived Stress (14 items)ᵇ	19.61 (8.05)	5–35	23 (46.9%)	26 (53.1%)	0

*One out of the 49 participants did not answer three of the four questionnaires
ᵃProfessional Quality of Life scale and subscale scores: low quality of life (≤22), moderate quality of life (23–41), and high quality of life (≥42).
ᵇPerceived Stress Scale scores: low stress (0–18), moderate stress (19–37), and high stress (scores 38–56).

Table 3. Multiple Regression Model Summary for ProQOL Subscales and Predicting Variables

QOL domain (predicting variables)	R	R²	Adjusted R²	F ratio	p
Compassion Satisfaction (distance technology experience, urban or rural location, and perceived stress)	.63	.40	.31	4.53	<.001
Burnout (employment status, perceived stress)	.83	.69	.65	14.87	<.001
Compassion Fatigue (perceived stress)	.50	.25	.21	6.70	<.001

Note. QOL = quality of life. *R* refers to correlation coefficient; R^2 = coefficient of determination and percent variance explained by each ProQOL subscale's independent variables.

Multiple Regression Analysis

Compassion Satisfaction

The average (mean) Compassion Satisfaction subscale score was 39.27, suggesting that participants perceived a moderate sense of compassion satisfaction (Table 2). The Cronbach's alpha reliability coefficient (α) for the Compassion Satisfaction subscale in this study was .92. Five predicting variables with $p < .20$ in the bivariate analysis were selected and entered into the multiple regression model: gender, having experience in distance technology, urban or rural location, community size, and perceived stress. Three of these variables were associated with compassion satisfaction in the model at significant levels: having experience in distance technology ($p = .010$), urban location ($p = .044$), and low levels of stress ($p = .002$; Table 3). Forty percent (40%) of the variance in compassion satisfaction could be explained by these three variables.

Burnout

The average Burnout score was 21.17, suggesting a lower sense of burnout among participants (Table 2). In this study, Cronbach's α was .79 for the Burnout subscale. Five predicting variables with $p < .20$ in the bivariate analysis (age, having full-time job, Catholic faith background, faith leader year of experience, and perceived stress) were selected and entered into the multiple regression model (Table 3). Having a full-time job ($p = .003$) and high level of perceived stress ($p < .001$) were the significant variables associated with burnout, where 69% of variance in burnout could be explained by these two variables.

Traumatic Stress

The average score on the Traumatic Stress subscale was 21.69, suggesting a moderate sense of traumatic stress (Table 2). Cronbach's α was .91 for the Traumatic Stress subscale in this study. Perceived stress as measured by the PSS was moderate with a mean score of 19.61. The Cronbach's alpha coefficient for the PSS in this study was .89. Two predicting variables (Catholic faith background and perceived stress) with $p < .20$ in the bivariate analysis were selected and entered into the multiple regression model. Perceived stress was the only significant variable associated with traumatic stress ($p < .001$) in the model (Table 3), where 25% of variance in traumatic stress could be explained by perceived stress.

DISCUSSION AND RECOMMENDATIONS
Care Provided During the Pandemic

Faith leaders and FCNs play a vital role in healthcare provision in rural communities and have been frontline sources of support for congregants since the beginning of the COVID-19 pandemic. Based on the findings from this study, both the leaders and FCNs provided multiple virtual services during the COVID-19 pandemic.

Home visitations were completed during the pandemic using virtual methods including video chatting on cell phones or computers via FaceTime and other video conferencing, phone calls, texts, and email. Choosing the virtual method that was most accommodating for the congregant supported successful caregiving. Nursing home visitations were halted for faith leaders who were not direct employees of the nursing home. Leaders and FCNs from outside of the nursing home setting were not permitted inside, but phone calls, texts, video conferencing, and FaceTime were used to remain connected with congregants within the nursing home setting. Nursing home staff helped facilitate these encounters.

Hospital visits were halted during the pandemic. Families struggled with the care needs of their loved ones within the confines of the acute care setting. Families and patients connected with faith community care providers using phone, virtual conferencing, and FaceTime methods. The leaders and FCNs

utilized the support of family members outside of the acute care setting as well as the support of the hospitalized patients to communicate with and care for congregants during the early days of the pandemic and extending into the winter months of 2020–2021.

Educational support was provided using Zoom virtual conferencing for meetings and recordings; some educational sessions were shared using YouTube and other platforms. Education centered on infection prevention in the early days of the pandemic and progressed to include education on vaccine safety and efficacy.

Most of the leaders and FCNs (60.4%) reported increased demand for distance-based interactions (e.g., consulting by telephone, answering email) during the COVID-19 pandemic. Leaders and FCNs were spending an increased number of hours reaching out virtually to provide support to individuals they would have normally seen at weekly worship gatherings. The elderly and most vulnerable congregation members required ongoing support, and additional congregants were suffering from the effects of isolation and needed virtual care support.

The FCNs played an integral part in their communities by providing congregants with necessary resources and linking them to additional care resources when needed, especially for low-income families who had limited access to services and information. The COVID-19 pandemic and shift of hospital care to the community added to the multiple roles played by faith leaders and FCNs within faith communities. The increasing demand during this time was stressful.

Impact of Pandemic on FCNs/Leaders

Most participants expressed that they were satisfied with their jobs and had moderate-to-high scores on the Compassion Satisfaction subscale. However, among those reporting high compassion satisfaction, over 40% reported moderate burnout, 38% reported moderate-to-high compassion fatigue, and over 50% reported moderately high perceived stress. Based on the multiple regression model, results confirmed that perceived stress was a key predictor for quality of life as measured by the ProQOL. When participants perceived low stress, they were likely to have better compassion satisfaction in their jobs. When perceived stress was high, they were more likely to have compassion fatigue and burnout. This finding is consistent with what other researchers have reported (Hotchkiss & Lesher, 2018; Jacobson et al., 2013; Visker et al., 2017).

Compassion fatigue was associated with experience in distance technology and working in an urban community. This may be due to the larger number of congregants who lived farther from family and friends, making them more dependent on faith community support. Although 85% of participants had experience in distance technology, they had to adapt to the rapid shift and demand, and the increase in online distance work could have contributed to higher stress levels. A shift from twice-weekly in-person worship services, where faith leaders and FCNs could engage with congregants, to all online worship services could have led to increased need for additional virtual interactions with the congregants. In rural settings, there often is limited high-speed Internet or cellular services. Without Internet and cellular services, the use of virtual tools such as video conferencing and texting is limited. Thus, the rural leaders and FCNs depended on the use of landline phones to reach their congregants. This is similar to what other researchers have reported (McNeely et al., 2020; Templeton et al., 2020).

Despite high levels of compassion satisfaction, the transition to alterna-tive modalities of virtual care appeared to have created increased compassion fatigue and decreased perceived quality of life for participants. It is important to recognize compassion fatigue within those serving the faith community so they can initiate self-care methods. This might include using a team-based approach so that no individual faith leader or FCN is carrying a heavier load and working as a team so that duplicate support services are not provided, especially during times of higher workload and stress. Team meetings for all faith leaders and FCNs with sharing, prayer, and support could be an important self-care tool. Finally, utilizing virtual conferencing that takes place in urban settings to provide education and support for congregants across rural settings could help offset some of the workload burden for rural leaders and FCNs (Keener et al., 2021a; 2021b).

Limitations

Limitations of this study included data collected in only one highly rural state and at only one point in time. Additionally, survey data were collected in May 2020 during the height of the stay-at-home order in West Virginia. The circumstances of these communities may have progressed over the remainder of 2020 and not been reflected in study data. Moreover, word of mouth and Facebook were the primary sources of participant recruitment. These recruitment strategies could produce limited data regarding the experiences of rural community members. Limitations in the questionnaire included the lack of distinction between time as a nurse versus time as an FCN. Education level of the FCNs was not assessed, which could have impacted care and response to the job. Another limitation is the lack of breakdown between the FCNs and faith leaders regarding tasks and full-time work settings. If completed again, the questionnaire should include a clear distinction between the two.

CONCLUSION

Faith community leaders, including pastors, priests, and FCNs, have played an important role during the COVID-19 pandemic in providing supportive care for congregants. Although this type of

support has been part of the roles of FCNs and pastors/priests in the past, circumstances surrounding the pandemic led to a need for change to the use of virtual encounters in place of in-person encounters. In addition to the traditional needs within a faith community, new needs associated with social isolation and environmental threats emerged. More congregants required psychosocial support than usual during the COVID-19 pandemic. Though the study findings revealed that high compassion satisfaction was reported among the leaders and FCNs, compassion fatigue also was experienced by many of them. Future research is needed to determine if this fatigue has continued beyond the first year of the pandemic. A need exists to determine strategies that support faith leaders and FCNs during stressful times as well as support emerging roles and caregiving to prepare them to work in stressful public health threats.

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