CE 1.5 contact hours

The Family Meal Challenge

A Faith-Based Intervention to Empower Families

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ABSTRACT: *African Americans have increased rates of overweight and obesity and are least likely to participate in family meals compared with other racial groups. A Family Meal Challenge (FMC) was developed with the objective of empowering individuals to eat healthy meals together as a family. The FMC was presented through four classes in three churches, two faith-based ministries, and two community service programs in health disparity zip codes. Surveys (N = 257) indicated a positive response. Engaging participants and teaching the benefits of eating healthy family meals in a faith-based environment are feasible and may increase the frequency of family meals. Information is provided to create and implement an FMC in any faith setting.*

KEYWORDS: *African American, faith-based, faith community nursing, family meals, healthy eating, obesity*

The obesity epidemic in the U.S. has caused a major public health crisis. From 2011 to 2014, 36.3% of all adults were classified as obese; 40.2% in the 40 to 59 age-group were obese (Centers for Disease Control and Prevention [CDC], 2018a). Obese individuals have an increased risk for chronic diseases, such as cardiovascular disease and its risk factors, infertility in women, osteoarthritis, respiratory distress, and some cancers (CDC, 2018b).

Obesity is more prevalent in certain geographical regions and zip codes than others. Although the increase of obesity is found in all ethnic and racial groups in the U.S., its prevalence is higher in non-Hispanic Black and Hispanic populations. According to the CDC (Ogden, Carroll, Fryar, & Flegal, 2015), 48.1% of non-Hispanic Black Americans are overweight, a rate higher than any other racial/ethnic

group. Non-Hispanic Black women have the highest rate of obesity (56.9%) compared with other subgroups. African Americans also disproportionately experience obesity-related diseases, including the incidence, morbidity, and mortality rates for hypertension, cardiovascular disease, diabetes, and cancer (CDC, 2015; Cowart et al., 2010). These rates of disparity are of great concern.

Numerous studies have highlighted the health benefits of frequent family meals (Berge et al., 2012; Chan & Sobal, 2011; Fruh, Fulkerson, Mulekar, Kendrick, & Clanton, 2011; Kant & Graubard, 2011; National Center on Addiction and Substance Abuse [NCASA], 2016; Neumark-Sztainer, Larson, Fulkerson, Eisenberg, & Story, 2010). Teens who communicate with their parents at the dinner table are less likely to have smoked cigarettes, used marijuana, or consumed alcohol (NCASA, 2012). Teens who frequently eat dinner with their families consume more fruits, vegetables, grains, and calcium-rich foods, and less soft drinks (Berge et al., 2012; Chan & Sobal; Gable, Chang, & Krull, 2007; Neumark-Sztainer et al.). A frequent, healthy family meal encourages nutritious eating and affects obesity rates. However, African Americans are least likely to participate in family meals compared with other ethnic groups (Kant & Graubard).

Compared with other U.S. populations, African Americans have a higher rate of church membership and have been distinguished as the most religious (Lewis & Taylor, 2009) and giving and receiving the most social support inside the church (Krause, 2016). Studies have shown that African-American churches can be an effective setting to promote nutritional education to members (Baruth, Wilcox, Laken, Bopp, & Saunders, 2008; Christie, Watkins, Weerts, Jackson, & Brady, 2010; Dodani, Arora, & Kraemer, 2014). Many African-American church leaders have identified the need to address the health issues of their congregation's members. Some assign priority to the health and well-being of their members by establishing special committees, as well as ministries that offer health services and health-related programs (Baruth et al.; Dodani et al.). The church has emerged as a vital partner in the effort to reduce health disparities (Austin & Harris, 2011).

Encouraging family meals is an important measure for improving dietary intake and ...strengthening family relationships.

THE FAMILY MEAL CHALLENGE

After an extensive literature review, we could not locate a study that implemented an educational intervention related to family meals for adults residing in health disparity zip codes. We hypothesized that increasing the frequency of healthy family meals in a low-income African-American population would have positive health benefits.

The *Family Meal Challenge* (FMC) was developed with the objective of empowering individuals to eat healthy meals together as a family. The FMC program teaches strategies for increasing family meal times and healthy eating. We implemented an FMC intervention in three churches, two faith-based ministries, and two community-service programs, all located in health disparity zip codes in a southeastern U.S. city. Health disparities can be addressed and reduced by providing health education that is culturally relevant (Lewis & Taylor, 2009). Thus, it made sense to use a faith-based approach for the FMC. The FMC program was designed to be compatible with faith-based approaches and can be used by any faith community nurse (FCN).

The purpose of the FMC intervention is to empower each participating family to eat healthy meals together. Ministers from the selected churches were supportive of the intervention and helped promote the project. The FMC content presentation included the spiritual significance of the family meal, as illustrated in Scripture as a place of encouraging instruction and of sharing stories of God's faithfulness and resilience (Deuteronomy 6), and a place of nurturing (Psalm 128). This article describes the results of the FMC study, along with lessons learned from this 4-week FMC intervention. We hope that by reporting on this research, an additional practical intervention—the family meal, may be incorporated into faith community nursing practice and promoting health and congregational wellness.

Participants were recruited from three churches, two faith-based ministries, and two community-service programs to participate in a study of the FMC intervention. Institutional review board approval was obtained for this project; adult participation was voluntary; and study participants signed an informed consent form. The sites of the FMC were selected to be within targeted health disparity zip codes. Thirty percent (30%) of the residents in the health disparity zip codes chosen for the study live below the poverty line and have higher rates of mortality from cancer and cardiovascular disease; 92% of the population is African American (Arrieta, White, & Crook, 2008).

At each location, classes were conducted weekly for 1 month. Class topics included:

1. Discussing the benefits of the family meal;
2. Providing information to assist with preplanning and preparing healthy menus;

3. Offering creative ideas to promote communication around the table;
4. Imparting strategies and tools to make healthy meals a reality (i.e., preparing meals ahead of time, freezing, and defrosting when needed).

Table 1 offers a more detailed description of each intervention session.

Each class opened with a cost-effective, easy-to-prepare cooking demonstration using a slow cooker. Tasting samples were prepared in advance and offered to the participants prior to the demonstration. There were 28 classes total, with 10 to 40 participants each. The church locations had the highest number of participants, averaging 40 participants per class.

An ambitious culturally sensitive interventional program, such as the FMC, is not created in a vacuum. The program used feedback from focus groups conducted with Community Health Advocates (CHAs) who live in and have extensive experience working with the study population (Fruh et al., 2013). Classes incorporated evidential strategies to identify the relevance of healthy eating and family meals to the target population. The classes were piloted with the CHAs to ensure that materials and presentations were culturally appropriate. The CHAs provided valuable critique of each class, and their recommendations were incorporated prior to the delivery of the program. This type of preintervention work is critical to success.

Table 1. Family Meal Challenge Sessions

Intervention Goals:	Intervention Activities:
Session #1	
• Increase knowledge of the importance of family meals (healthier meals, stronger family bonds, and family cohesiveness). • Learn strategies to increase frequency of family meals and to promote a healthy eating environment.	• Open class with a cooking demonstration and taste testing (healthy, low-cost meal). • Detailed overview of the many benefits of healthy frequent family meals. • Common barriers to family meals. • Strategies to help with meal scheduling; how to work with sports events (i.e., tailgating a meal).
Session #2	
• Increase meal planning and strategies to help with grocery shopping (grocery lists, online programs, stocking pantry). • Provide helpful strategies to increase healthy, quick, and easy-to-prepare meals. • Identify ways to incorporate cost-effective fruits and vegetables in menu.	• Open class with a cooking demonstration and taste testing (healthy, low-cost meal). • Meal planning for 1-week time period; successful methods to preplan. • Ways to stock a pantry for quick, easy, healthy meals. • Ways to increase fruit and vegetable consumption. • How to involve family members in sharing meal planning.
Session #3	
• Develop strategies to increase family communication around the table. • Provide strategies such as conversation cards and positive communication. • Encourage families to avoid negative topics at the meal table. • Create a positive meal environment by decreasing TV viewing and use of electronics during meals.	• Open class with a cooking demonstration and taste testing (healthy, low-cost meal). • Overview of the importance of communication around the table and positive communication patterns (i.e., open-ended questions to promote discussion). • Discuss best approaches to help ensure a peaceful table environment (i.e., turn off TV, cell phones, and all electronics).
Session #4	
• Increase availability of healthy meals in the home (freeze healthy meals for later use, use of time-saving devices such as a slow cooker). • Increase the practice of menu planning and cooking multiple meals at one time and freezing meals for later use. • Increase the practice of planning meals in advance.	• Open class with a cooking demonstration and taste testing (healthy, low-cost meal). • Detailed instructions of preparing several meals at a time and freezing extra meals for later use (freezer storage information). • Easy, healthy main dish, side dish, dessert, and snack recipes. • Information given on healthy recipes that freeze well. • Time-saving meal plans, that is, slow cooker cooking, healthy breakfast shakes, and so on.

EDUCATIONAL PROGRAM AND EVALUATION

All sessions were conducted by the principal investigator to ensure that teaching sessions were equivalent. Each participant received a three-ring binder. At the start of each class, researchers handed out the educational materials for that session. The handouts were prepunched for easy addition to the binder and recipes were included. The goal for the binder was to serve as a current and future resource for participants.

Participants who completed the program received conversation starter kits to kick start communication during family meals. The kit included a jar with color-coded, age-appropriate, open-ended questions. The outside of the jar included a color-coded legend corresponding to appropriate questions for each age-group. For example, the conversation jar had table talk starter questions that ranged from general family topics, children ages 3 to 5, children ages 6 to 17, parents, and couples. An example from the 3- to 5-year age-group would be: "What is your favorite family activity?" and "What makes you feel better when you are scared?" An example from the general family topics includes: "What do you appreciate most about the family member sitting on your right?" or "If you could choose any home cooked meal to eat, what would it be?" and "If you and your family could have dinner with anyone in the world, who would you choose and why?" Resources for developing family meal conversations can be found in Table 2.

Table 2. Resources for Developing the Family Dinner

- ***Belonging and Becoming: Creating a Thriving Family Culture*** by Mark Scandrette and Lisa Scandrette, 240 pp., 2016, IVP Books.
- ***The Family Dinner: Great Ways to Connect with Your Kids, One Meal at a Time*** by Laurie David with Kirstin Uhrenholdt, 256 pp., 2010, Hatchette Book Group.
- ***365 Family Dinners and Devotions Cookbook: A Celebration of Food, Family, and Faith*** by Kathleen Y'Barbo, 384 pp., 2016, Barbour Books.
- ***The Family Dinner Project***—https://thefamilydinnerproject.org/conversation/conversation-starters
- ***Mom It Forward***—http://momitforward.com/dinner-discussion-questions-printables/
- ***Aha! Parenting***—http://www.ahaparenting.com/parenting-tools/communication/family-discussions

Table 3. Future Classes of Interest to Participants

Education on Food Choices
• How to read side labels for nutrition
• Diet for diabetics
• Eating tips for dieters
• Eating healthy for weight reasons (i.e., baked vs. fried)
• Best dinner beverages
• Healthy beverages, how to make water taste different for children
• Calorie count information
• Food plate/pyramid
• Grocery shopping tips
• Are plastic containers safe for food storage?
• How much should you spend on one meal?
Meal Planning
• More information on menu planning
• Planning before shopping
• Planning food for the senior citizen
• Planning smaller portions for singles, widows, etc.
• How to find food discounts or coupons
Family Meals
• Family meals; helpful ways to get everyone to gather around the table
• Family meals with grandchildren
• How to plan family meals
Food Preparation—What Participants Want
• More recipes, healthy dessert options/recipes, heart-healthy recipes
• How to steam and cook veggies properly so their vitamins/minerals/nutrients are not lost
• How to prepare healthy fried foods
• How to cook sweets without all the sugar
• Healthy cooking for picky eaters
• Quick cooking
• Meals children/the family would enjoy cooking together
• Baking in the slow cooker
• Canning safety
• Vacuum-pack freezing

After each weekly class and at the end of all classes, participants provided feedback on class effectiveness. They also completed an overall program evaluation 2 months after the last class. All surveys were completed anonymously. The surveys were developed in consultation with national and local experts, who work with individuals residing in health disparity zip codes. The surveys were piloted with 18 CHAs to ensure the questions were appropriately structured for literacy level and cultural relevance. The surveys were designed to capture both quantitative and qualitative data.

The evaluation survey for each session included six questions. The last question in the survey was open-ended and provided qualitative feedback (Table 4). The overall evaluation survey given at the end of the FMC intervention consisted of nine questions (Table 5). Quantitative data from the surveys were entered into Excel spreadsheets and analyzed using *JMP* (a product of SAS, Inc., Cary, North Carolina). Responses were summarized using percentages. For comparison, answers of "strongly agree" and "agree" were grouped together, and answers of "disagree" and "strongly disagree" were grouped together.

FMC INTERVENTION RESULTS

There were 257 participants in the FMC intervention study. The majority were African-American females (n = 175, 68%). Forty-seven percent (47%) of participants were married, and 55% had children living at home. The final survey was completed by 146 participants (57%).

In the individual surveys collected at the end of each class, participants reported they received a great deal of practical information about family meals and had learned new information. The majority rated classes as excellent; 98% identified they would recommend this class to friends. The participants provided helpful suggestions for future classes, reported in Table 3. They were interested in practical strategies related to healthy eating, healthy cooking, and meal preparation. Questions for the individual class survey are in Table 4. These questions would be helpful for FCNs to use in evaluating an FMC intervention in their faith community settings.

The overall program evaluation also yielded positive results (Table 5). When asked how much practical information they gained from this program, 72% stated a great deal and 27% reported some practical knowledge. Eighty-five percent (85%) strongly agreed that the program provided practical tools needed to increase the number of family meals; 69% strongly agreed that the program provided practical tools to help with communication and conversation around the table; and 75% reported they learned new information about family meals and its effects on the family. Participants were asked to give an overall rating to the program: 76% rated excellent, and 24% rated good. Ninety-three percent (93%) reported they have a stronger interest in improving family meals because of this program. The summary evaluation would be helpful for FCNs when implementing the FMC in their settings.

Comments made on the open-ended questions on the surveys support the quantitative data results. Representative comments from participants include: "I enjoyed the class. Teaching learning strategies were very good." "Preparing the meal and allowing us to sample the meal was very well implemented." "This program has helped me learn ways to have family meals together and get my son to open up to us about things that happen in his life."

DISCUSSION

We sought to implement an FMC program to encourage an increase in the frequency of family meals in a population whose members are at high risk for obesity and who are less likely to eat family meals. We used a faith-based approach in faith and community settings. Participation was good within each class and the overall program was well received. Participants felt they were more likely to increase family meals and were highly likely to recommend such an intervention to a friend.

Family meals are associated with better dietary intake and show a promising reduction in excess weight gain in prepubescent children (Fulkerson et al., 2015). One study identified that adolescents with any level of baseline family meal frequency had a lower chance of being affected by overweight or obesity 10 years later than adolescents who never ate family meals (Berge et al., 2015).

These study results suggest that even among families in health disparate communities, the advantages of family meals can be effectively taught. The significance of being able to implement an obesity reduction program in a health disparate population cannot be overlooked. Obesity rates in Alabama are among the highest in the U.S. African-American adults in Alabama have the highest self-reported rate of obesity among African Americans in the nation (CDC, 2017).

Frequent, healthy family meals encourage healthy eating and lower obesity rates. However, the beneficial effects of family meals can be undone by watching television during the meal (Escobar-Chaves et al., 2010; Feldman, Eisenberg, Neumark-Sztainer, & Story, 2007; Fitzpatrick, Edmunds, & Dennison, 2007; Gable et al., 2007). One study noted that families with preschool-age children participating in meals together have more servings of fruits and vegetables; however, with the television on during the meal, the servings of fruits and vegetables declined (Fitzpatrick et al.). Our participants demonstrated that they learned these and other important lessons during the FMC. It will be important to evaluate whether the participants were able to turn their knowledge into sustainable behavior that resulted in structured and frequent family meals.

There were several limitations to this study. Not all participants who took a postintervention survey completed the overall program evaluation, and not all questions were answered. Although the majority completed the four classes, not everyone completed the postintervention survey. However, verbal and survey feedback following each session is consistent with the survey data from the overall program evaluation. Study findings may not be generalized in other locations and may not be applied to nonfaith-based venues. However, the findings add to the knowledge base of family meal benefits and the impact of a family meal intervention program in communities that are at highest risk for obesity.

IMPLICATIONS FOR RESEARCH, PRACTICE

Future research based on the study results should be considered. Although recommending a correlational design after an interventional study might seem counterintuitive, a correlational research design could identify the relationships among variables that include demographics, family dynamics and structure,

Table 4. Survey Questions for Evaluation of Individual Classes

QUESTION:	RESPONSES:
1) How much practical information about family meals have you gained from this class?	A great deal Some practical knowledge None
2) Have you learned any new information about family meals that you were not aware of?	Very much so Some None
3) What overall rating would you give this class?	Excellent Good Average Poor Very poor
4) Would you recommend this class to your friends?	Yes No
5) Do you have a stronger interest in family meals because of this class?	Yes No
6) List subjects you would like included in this class.	Open ended

developmental stage of the children living in the home, work status of parents, and weekly family meal practices. These results could be used to tailor the intervention and test more completely. Replication of this interventional study is encouraged. In addition, researchers could consider tracking behavior change among family members and identifying the impact on biomarkers. Also, researchers should consider altering the setting of future studies on this topic. The setting can be limiting to the findings if parents have limitations with childcare, work schedule, and informal and formal support systems.

Encouraging family meals is an important measure for improving dietary intake and communication around the table and for strengthening family relationships. All healthcare providers should ask families about their family meal habits and encourage them to gather around the table. However, health in spirit, mind, and body are specific goals of FCN practice. This study demonstrated the feasibility of teaching families to eat healthy meals together. Faith community nurses can offer similar classes to address the benefits of family meals, preplanning, and communication around the table. Classes could focus on time-saving strategies such as using the slow cooker cooking method and freezing prepared foods/meals to make family meals a reality in the homes of participants. Easy, healthy main dish, side dish, dessert, and snack recipes could be provided as a resource to assist with dietary intake. To help promote communication and healthier eating, it also is important to encourage families to turn off the television and electronics while they eat. Using a conversation starter kit as described in this intervention helps to develop family communication and provides an alternative to electronic distractions. Relationships deepen as true communication occurs around the table. When active listening to all family members occurs, each family member feels valued and this results in warmer relationships and greater understanding of each other's perspectives. Nurses are encouraged to try this evidence-based intervention as part of their health ministry practice.

Numerous studies have highlighted the health benefits of frequent family meals.

Table 5. Overall Program Evaluation Survey

QUESTION:	RESPONSES:
1) Overall, how much practical information have you gained from these classes?	A great deal Some practical knowledge None
2) Overall, has this program provided practical tools to help you increase the number of family meals?	Strongly agree Somewhat agree Neither agree nor disagree Somewhat disagree Strongly disagree
3) Overall, has this program provided you with the practical tools needed to help you increase the number of healthy meals?	Strongly agree Somewhat agree Neither agree nor disagree Somewhat disagree Strongly disagree
4) Overall, have the classes provided you with the practical tools to help you with communication and conversation around the table?	Strongly agree Somewhat agree Neither agree nor disagree Somewhat disagree Strongly disagree
5) Have you learned any new information about family meals and its effects?	Very much so Some None
6) What overall rating would you give this program?	Excellent Good Average Poor Very poor
7) Would you recommend this program to your friends?	Yes No
8) Do you have a stronger interest in improving family meals because of this class?	Yes No
9) List any areas you would like to be included in future classes, suggestions for improvement, or other comments.	Open ended

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