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Research Article

Evaluation of a Faith-Based Stress Management Program "Trinity Life Management" In a Rural African-American Community

Bryant K*, Haynes T and Willis N
Fay W Boozman College of Public Health, University of Arkansas for Medical Sciences, USA

***Corresponding author:** Keneshia Bryant, Associate Professor, Fay W. Boozman College of Public Health, University of Arkansas for Medical Sciences, 4301 West Markham Street, Slot #820, Little Rock, Arkansas 72205, USA

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Abstract

The Trinity Life Management: A Faith-Based Stress Management intervention was developed by an academic research team in partnership with a rural African-American faith community following the principles of community based participatory research. The purpose of this collaboratively designed intervention is to provide parishioners the techniques and tools they need to effectively cope with stress and minor depression symptoms. This can be done by enhancing their knowledge of the stress-distress-depression continuum, increasing their ability to distinguish between stress and depression, and strengthen their self-efficacy in performing coping behaviors. The intervention is co-led by lay health leaders, Trinity Leaders. The purpose of this feasibility pilot study was to test the protocols, procedures, and processes of the study; track recruitment, retention, and attrition; monitor the fidelity of the intervention; and obtain Trinity Leader and participant evaluations of the study experience. There were a total of 20 participants. The study results suggested that additional leader training would be needed to address beliefs about the causes of depression and stigma. Also, in an effort to reinforce the intervention delivery process and maintain consistency, there should be incorporation of standardized scripts for the lay leaders. In addition, further role plays and practice sessions are needed to enhance facilitation skills. Finally, changes in the recruitment of participants and the inclusion criteria to identify those most in need of the intervention.

Keywords: Stress; Faith; Rural; African-American; Community based participatory research

Introduction

Although stress can be useful in certain situations, chronic stress is related to cardiovascular disease, metabolic syndrome, obesity, emotional overeating, and depression [1-6]. This is especially concerning for African- Americans living in rural areas because they are exposed to high levels of chronic life stress related both to their rural residency and their race/ethnicity. Not only can stress have detrimental effects on one's physical health, but also negatively impacts one's mental health. Ethnic groups that tend to experience high rates of stress, such as African-Americans, tend to report high levels of psychological distress, which is often a risk factor for the development of psychiatric disorders [7,8]. Life stressors of rural African-Americans put this population at particular risk for depression and other health related issues [7]. In addition to stress, lack of social support and inadequate coping processes has been linked to risk of depression [9,10]. In a recent report, persons 45-64 years of age, African-Americans, persons with less than a high school education, individuals unable to work or unemployed, and persons without health insurance coverage were more likely to meet the criteria of depression [10]. Given the negative impacts of stress on both mental and physical health, it is important to support stress self-management among rural African-Americans, not only for those who manifest a disease or disorder, but also for healthy people. A holistic approach to stress self-management that incorporates ones faith may prove to be an effective means of mental health promotion.

Background

Faith has been shown to aid in more effective handling of stressful events [11-13].This is particularly true among African-Americans, who give great importance to spirituality including the use of prayer and faith to cope with stress [14-18]. Additionally, African-Americans tend to seek support from their community, neighborhood, and family when faced with stress. The church, as one of the most trusted institutions in rural African-American communities, often serves as a venue for receipt of social support and information, making churches an ideal setting for stress management programs. Churches are available in nearly every community and because of their mission of service and caring for others; they have served as the site of a variety of health promotion programs [19-21]. A majority (59%) of African-American faith communities attend historically Black denominational traditions, which include the National Baptist Convention, Methodist, and Pentecostal churches. Approximately 7,500 religious congregations exist in Arkansas, of which about 10% are characterized as historically Black denominational traditions [14]. This estimate is higher than the national average. Informal church-based networks can help make mental health promotion programs successful [22,23] and they can be of particular advantage in rural, lower socioeconomic communities. Yet, very few interventions addressing stress issues

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Table 1: Trinity Life Management session outline.

Session 1	*Stress Management and working with God*: This session provides an overview of the "Health Trinity Model" in which the spirit is the core, flowing throughout the mind, body, and emotions, which are interconnected and make up a person. Balance is needed to maintain wellness, and stress in any part of the person can cause an imbalance.
Session 2	*Stress-Distress-Depression Continuum*: This session discusses mental health and provides definitions of stress, distress, and depression. The session also provides an overview of stress and how it is linked to depression. It provides participants information about causes, signs and symptoms, diagnosis, and treatment of each.
Session 3	*My Body is a Temple: Exercise and Nutrition/Eating Healthy*: This session provides information on how exercise can be used to decrease stress and the importance of treating one's body as God's temple. The session, also provides information on how nutrition can be used to improve mood. In addition, it emphasizes the importance of treating one's body as God's temple by eating a healthy diet while stressed.
Session 4	*My Body is a Temple: Preventive Healthcare*: This session provides an overview of measures to maintain wellness through preventive efforts. The session emphasizes that stress can have negative impacts on the body, which may lead to hypertension or other health problems.
Session 5	*Communication and Feelings & Emotions*: This session describes how communication with oneself, God, and others, including healthcare providers, can impact the Health Trinity. It provides tips for effective communication, and explains how the mind differs from emotions. It also gives details about how common emotions such as anger, compassion, and love impact one's stress level and overall well-being. Tips on managing one's emotions are also discussed.
Session 6	*Balancing and Maintaining the Trinity*: This session brings together all of the information in the previous sessions to aid in maintaining the lessons learned.

Table 2: Participant outcome measures.

Scale/Questionnaire	Brief Description	Number of Items
Perceived Stress Scale	Non-specific stress appraisal	10-item
Coping Self-Efficacy (CSE) scale	Measure of one's confidence in performing coping behaviors when faced with life challenges	26-item
Depression Stigma Scale	Measures levels of depression stigma	9-item
Patient Health Questionnaire (PHQ-9)	Assesses current symptoms of depression	9-item
Generalized Anxiety Disorder (GAD-7) Scale	Self-report anxiety questionnaire	7-item
Brief Multidimensional Measure of Religiousness/Spirituality	Domains measured: daily spiritual experiences, values/beliefs, forgiveness, private religious practices, religious & spiritual coping, positive religious/spiritual coping & negative religious/spiritual coping, religious support, organizational religiousness, religious preference, overall religious/spiritual self-ranking	48-item
Spiritual Health Locus of Control Scale II	Multidimensional scale comprised of active and passive spiritual dimensions	13-item

have been developed and tested in the African-American community [24,25]. And there are no evidence-based depression prevention interventions targeting the rural African-American faith community [26]. Therefore, the *Trinity Life Management*: A Faith-Based Stress Management Intervention was developed using a Community Based Participatory (CBPR) approach. This paper discusses the evaluative process of a feasibility pilot study.

Trinity Life Management: A Faith-Based Stress Management Intervention

Trinity Life Management is a 6-week, gender-specific group intervention designed to promote stress self-management based on the theory of self-efficacy and on social network theory [27,28]. The intervention addresses the stress-distress-depression (impairment) continuum [29-31] and provides parishioners the self-management tools and techniques they need to effectively cope with stress. The goals are to 1) enhance participants' knowledge of the stress-distress-depression continuum including risk factors, symptoms and consequences; 2) increase participants' ability to distinguish between experiences of stress and depression; and 3) strengthen participants' coping self-efficacy in performing stress self-management when faced with life challenges. In addition, participants acquire tools to achieve effective communication and self-reflection.

Trinity Life Management is co-led by lay health leaders, called Trinity Leaders. All weekly sessions of the intervention follow a similar format: open with a welcome and prayer requests, followed by a prayer, a review of the prior week's lesson (during the first week an overview of the program is given), the current week's lesson(s), and a closing prayer. Each of the weekly sessions lasts approximately 90 minutes. All session topics are included in the participant notebooks (Table 1). The notebooks also include local and regional social and health resources in the appendix. The intervention teaches participants a variety of stress self-management techniques, goal-setting, and evaluation to individualize strategies to cope with stress. The specific details regarding the development process of the intervention was published elsewhere [32,33].

Trinity Leaders Training

In general, individuals are more likely to select programs that are delivered in their own communities by individuals of their own racial background. In order for community mental health programs to engage rural African-Americans to address the health and health literacy needs of individuals, self-management programs should be delivered with cultural sensitivity [34,35]. Therefore, lay health leaders (referred to as Trinity Leaders) were recruited from the Community Advisory Board (CAB) developed for the formative studies and based on recommendation by a CAB member. The lay health leaders recruited all resided in the county and were African-American.

Two males and two females were recruited as Trinity Leaders to deliver the *Trinity Life Management* intervention. The lay leader training was modified from a faith-based weight loss program, lay leader training [36], and included a structured leader manual to aid in facilitation of intervention sessions. Modes of delivery included PowerPoint presentations, group discussions, reading assignments, and role playing. The initial in-person training was approximately 16-hours over two days at a local church, in addition to a 1-hour booster training after the third session. The CAB thought it was important for leaders to have knowledge of the Bible, experience

Table 3: Participant demographics.

Gender	Male	10	50%
	Female	10	50%
Age	18 – 30	4	20%
	31 – 50	9	45%
	51 – 70	4	20%
	70+	3	15%
Education	<High School Diploma	3	15%
	High School Diploma	8	40%
	Some College	7	35%
	College Graduate	2	10%
Religion	Baptist	17	85%
	Pentecostal	3	15%
Employment	Full-time	4	20%
	Disabled	5	25%
	Unemployed	5	25%
	Retired	3	15%
	Student	2	10%
Income	< $20,000	14	70%
	$20,000-50,000	5	25%
	$50,000-100,000	1	5%
Marital Status	Never Married	7	35%
	Married	5	25%
	Separated	1	5%
	Divorced	4	20%
	Widow	3	15%

in leading groups, and be respected in the community. With these criteria as a basis, the training included information on group facilitation, co-leading, and being non-judgmental. Additionally, leaders were educated on the stress-distress-depression continuum, the connection between faith and health, and stress management strategies. As part of the training, the Trinity Leaders completed the Collaborative Institutional Training Initiative (CITI) protection of human subjects training on-line. The CITI training program was conducted because the intervention involved the use of human subjects [37]. The Trinity Leaders received a stipend ($200) for completing the entire training for the intervention and delivery of the program.

Participants

The target population for this feasibility pilot study included English speaking men and women (18 years and older) who lived in a northeastern county of Arkansas [38]. Although the intervention is framed as a "stress management intervention," it was open to all who believed they might benefit from the intervention as a means of mental health promotion. This was primarily because prevention programs involved in changing health behaviors in African-American churches have generally been successful when all members were allowed to benefit from the services [20,39,40] and there is a lack of adequate mental illness diagnoses in this population due to stigma, lack of recognition, and access to healthcare.

Recruitment of the intervention participants began immediately after the Trinity Leaders completed their initial training. The primary recruitment strategy was word of mouth, led by the Trinity Leaders. Also, flyers were developed by the CAB and the academic team for distribution in the community. The CAB suggested limited recruitment for the study because all those interested could not be accommodated. An informational session was held for those interested in participating in the study one evening at a local church (the intervention site). Potential participants were informed about the study purpose, potential risks and benefits to participants, eligibility requirement and incentives. Those eligible to participate were given the opportunity to complete the consent process and the initial measures at that time.

The study protocol included a variety of retention incentives. Healthy snacks were provided during the weekly sessions. Participants who did not attend a weekly session were contacted by one of the Trinity Leaders to encourage attendance and share the details of the week's content. Participants received a $30 Wal-Mart gift card at the conclusion of the last meeting. Those who were not present at the final meeting were mailed the program evaluation forms, measurement tools, a self-addressed envelope, and the $30 Wal-Mart gift card.

Evaluative Process

In order to evaluate the feasibility of the intervention, a variety of process evaluation methods were used including a project log, participant tracking log, participant evaluations, and lay health leader evaluations, and participant outcome measures. The *project log* documented the protocols, procedures, and processes of the study, in addition to participant comments and researchers' observations. This log was used throughout the study and updated at least weekly by a research team member, to use as a tool for future reference. The *participant tracking log* was used to track recruitment, retention, and attrition throughout the intervention. A *fidelity* check-in to evaluate the Trinity Leaders delivery of the intervention to ensure it adheres to the protocol. *Participant evaluations* assessed the experiences of study participation immediately after intervention completion. Questions included: 1) how would you improve the program? 2) What was the one thing you liked best about the program? 3) What could be done to improve the program or, what would you like included in the program? 4) Other comments about your experience. The Trinity Leaders were asked to provide feedback regarding the intervention materials, format, and their perceptions of the participants' engagement.

Lastly participant outcome measures were evaluated. We wanted to determine whether the self-report measures listed in Table 2 could be completed with relative ease and adequately capture the desired information about the participants. Participant outcome measures were completed by participants at baseline (one week prior to beginning the intervention) and after the completion of the final intervention session using a paper and pencil format. In addition, participants were offered assistance to complete the forms due to literacy and impaired vision.

The measures selected for the study included primary and secondary outcomes identified by the research team. The primary outcome was Coping Self-efficacy, this scale measures one's confidence in performing coping behaviors when faced with life challenges [41]. The secondary measures included the following: 1) The Depression Stigma Scale is designed to measure stigma associated with depression. It has two subscales which measure two different types of stigma: personal and perceived. Only the Personal Stigma subscale was used for this study. It measures the respondents' attitudes towards depression by asking them to indicate how strongly they personally agree with nine statements about depression [42]. 2) Patient Health Questionnaire (PHQ-9) assesses current symptoms of depression. The instrument is used as a diagnostic tool and to measure severity [43]. 3) Generalized Anxiety Disorder Scale screens and assesses severity of anxiety in clinical practice and research [44].

Though the intervention was not designed to decrease the participant's stress, a measure was used to evaluate perceived stress. The Perceived Stress Scale assesses the degree to which people perceive their lives as stressful [45]. Two additional scales were used to characterize the participants; these included the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS) and the Spiritual Health Locus of Control Scale II [46-48].

Evaluative Outcomes and Discussion

A total of 20 participants (10 males and 10 females) were enrolled in the feasibility pilot study. Their average age was 45.5 (20-80) years; 85% self-identified as Baptist and 15% Pentecostal; 70% had a household income of $20,000/year or less. The majority (75%) of participants had a high school diploma and/or some college or trade school (Table 3). Recruitment efforts were led by the CAB and Trinity Leaders, but there was some confusion among the CAB members regarding the purpose of the information session, and as a result attendance was poor. This confusion led to intense efforts to recruit enough participants, but, some participants who were recruited and consented to participate did not fully participate in the intervention. The participant log reported the completion of participant measures and the number of sessions attended. Unfortunately attendance at the weekly sessions was sporadic and attrition was high. Six of the participants attended only the first session, although three participants attended all six sessions.

The *project log* included details regarding the recruitment process, the intervention protocol and research team observations. The major issue described in the log was a miscommunication between the academic team members and the CAB in regards to recruitment. A Trinity Life Management recruitment information session was scheduled at a local church. Unfortunately, the CAB did not realize the session was intended for them to bring and invite community members to hear about the intervention and potentially participate. The CAB thought the session was for them only. This caused a delay by one week in beginning the intervention. Additionally, the research team recognized the need to reiterate to the Trinity Leaders the goals, objectives, tasks, and purpose of the *Trinity Life Management* throughout the 6-weeks of the intervention.

Also noted, the *Trinity Life Management* workbook was primarily written and developed by persons with education beyond a high school diploma. Due to time constraints and funding, the materials were not reviewed for community members who may have lower literacy. Therefore, intervention materials need to be assessed for readability, reading level, and consideration of health literacy. Because it involves skills, decisions, and actions, health literacy has been described as a "foundation for self-management" [24]. The skills and competencies associated with health literacy are necessary for individuals with stress and psychological distress to make daily health decisions, take actions, and become engaged and empowered to manage their own health. Furthermore, limited health literacy has been identified as a barrier to self-management for low income minority individuals [49].

Based upon the *participant tracking log*, attendance of some of the participants was sporadic; therefore, more emphasis needs to be placed on recruitment of persons who are able to complete the intervention. This may be based on the day and time of the intervention sessions or possibly the time of year. A screening process to identify those who consider themselves stressed and limiting the age range should improve the recruitment of those who will complete the intervention. This is primarily due to the identified generational differences. Based upon the CAB and Trinity Leader feedback, primary recruitment strategies should be word of mouth, church bulletins, radio announcements, email blasts, and fliers.

The *fidelity* of the intervention was monitored by the first author using a checklist during session three. The checklist included the topic sections to be covered and information required for the session. The Trinity Leaders in one group however did not follow the standardized format and veered from the topics to be discussed for the week. The leaders did express confidence in applying the techniques, learned from their training, to the *Trinity Life Management* program. Though based upon the fidelity check-in, additional Trinity Leader training and discussions would be needed to address beliefs about the causes of depression (e.g., demons) and the stigma associated with it. To reinforce the intervention delivery and maintain consistency, the training manual should include standardized scripts for Trinity Leaders, and more role plays and practice sessions to enhance facilitation skills.

In their *participant evaluations*, the participants said that they enjoyed the "instructors", "conversation", and "learning new information about health." Recommendations for improvement included 1) meeting more often or more than 6 weeks; 2) providing more food during the sessions; and 3) including healthcare professionals as guest speakers for some of the sessions. After the intervention was completed, Trinity Leaders were also asked to evaluate the intervention, providing verbal feedback to the lead author as a group. They suggested limiting the age range of participants because of noted generational differences. The leaders also wanted to add more scriptures, Biblical stories, and prayers.

The *participant outcome measures* paper-pencil process was a challenge for some of the participants due to vision problems (e.g., required reading glasses) and low reading level and comprehension. Participants who requested help were assisted by the research team. But, due the number of participants requiring assistance outnumbered the research team which led to delays in data collection. Also, the measures did not all match or capture the intent of the intervention and desired outcomes. Because of the limited number of participants completing the pre and post measures, statistical analyses could not be conducted to determine effectiveness of the intervention.

Based on this feasibility pilot study, some of the participant outcomes measures are not appropriate. The Depression Stigma Scale and the Generalized Anxiety Disorder Scale do not fit the purpose and intent of the intervention. And only selected measures from the BMMRS should be used describe the participants. To adequately capture the stress-distress-depression continuum, the Psychological Distress Scale K6 should be added to the Perceived Stress Scale, and Patient Health Questionnaire (PHQ-9). Finally, the Perceived Knowledge of Depression Scale and Health Literacy measure should be added to capture changes in depression knowledge and level of participants' health literacy.

Because of the identified challenges completing the measures

other processes should be considered including: 1) the paper-pencil method could be provided to all participants in a group and each question read aloud by a research team member, with other research team members available for assistance; 2) I-pads with audio step-by-step instructions and measures could be provided to each participant, with research team members available for assistance.

Conclusion

Despite noted difficulties with recruitment and lay health leader training, Trinity Life Management shows promise as a faith-based stress management program for use with rural African-Americans. In addition to making the suggested changes to the intervention and addressing literacy levels, a number of lessons were learned. Theses include the need for better strategies for recruiting participants in rural communities for mental health research; a streamlined process for implementation of protection of human subjects training for lay health leaders; and the continued partnership with CABs to address mental health research needs in these communities.

The next step is to conduct a study to obtain variance estimates and effect sizes for a larger randomized controlled trial to determine the extent to which the *Trinity Life Management* intervention improves coping self-efficacy, psychological distress, and symptoms of depression. The *Trinity Life Management* intervention is designed for the African-American faith community in the Arkansas Delta. Given the health disparities for this population and their wariness about interventions imposed by "outsiders," a community approach is important.

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