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Development of a Faith-Based Stress Management Intervention in a Rural African American Community

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Abstract

Background—Faith-based mental health interventions developed and implemented using a community-based participatory research (CBPR) approach hold promise for reaching rural African Americans and addressing health disparities.

Objectives—To describe the development, challenges, and lessons learned from the Trinity Life Management, a faith-based stress management intervention in a rural African American faith community.

Methods—The researchers used a CBPR approach by partnering with the African American faith community to develop a stress management intervention. Development strategies include working with key informants, focus groups, and a community advisory board (CAB).

Results—The community identified the key concepts that should be included in a stress management intervention.

Conclusions—The faith-based “Trinity Life Management” stress management intervention was developed collaboratively by a CAB and an academic research team. The intervention includes stress management techniques that incorporate Biblical principles and information about the stress–distress–depression continuum.

Keywords

Mental health; community-based participatory research; rural health; spirituality; African American

Good mental health is essential to a person’s ability to live a full and meaningful life; further, mental health and physical health are intimately linked. Evidence has shown that mental health disorders, especially major depressive disorder (MDD), are strongly associated with increased occurrence of hypertension, diabetes, heart disease, cancer, and other chronic conditions.^{1–4} Up to 50% of those with chronic conditions also suffer depression, and persons with some chronic illnesses, such as diabetes, are at particularly high risk for MDD.^{5,6} The prevalence of MDD is roughly twice as high among patients with diabetes as among the general population.⁷ Clearly, early diagnosis and treatment of MDD could decrease the burden of mental health disorders as well as associated chronic diseases.

Rural African American communities have poorer health and fewer health care providers than urban communities, particularly in the area of mental health, and they experience more stigma associated with mental illness.^{8,9} Barriers to seeking and receiving adequate mental health care are longstanding for rural African Americans, including limited access to mental health providers, insufficient mental health training and education of local health care providers, and limited awareness of mental disorders.^{10–12} African Americans are more likely to receive an inaccurate diagnosis than Caucasians, and more likely to receive inferior mental health care.^{8,12,13} Further, even with improvements in access to quality mental health services,^{8,14} African Americans continue to underuse those services.^{13,15,16} In part this is because improving access does little to address perceptual barriers experienced by rural African Americans, including stigma.

Delays in seeking treatment for mental issues have also been associated with low mental health literacy.^{17,18} Recently, cultural barriers, language, doctor–patient relationships, and reliance on the support of the religious community have been identified as factors affecting African Americans' use of mental health care.^{19,20} Thus, cultural preferences and beliefs need to be taken into account in devising interventions to address depressive symptoms.

Faith has been found to aid in handling stressful events,^{21,22} and African Americans have been shown to give great importance to spirituality in care for depressive symptoms,^{19,23} including the use of prayer and faith. African Americans also seek support from informal networks, their community, neighborhood, and family. In rural African American communities, the church is one of the most trusted institutions, with a long history of shaping community values and norms. Rural African American churches have also served as community “gateways” or venues through which advances in health care have been translated into real world settings. Churches are available in nearly every community, and because of their mission of service and caring for others; they serve as the site of numerous health promotion programs. They can thus help to make mental health programs more successful.²⁴ African American pastors and the church are often on the front line, counseling persons with mental health problems.^{25,26} This can be a great advantage in rural, lower socioeconomic communities. However to date, no evidence-based depression interventions have targeted the rural African American faith community.²⁷

COMMUNITY ENGAGEMENT AND PARTNERSHIP

CBPR has been identified as a vital approach to eliminating health disparities.²⁸ The University of Arkansas for Medical Sciences (UAMS) Translational Research Institute has a Community Engagement Core that fosters collaborative partnerships among lay, health practice, and academic communities. These partnerships are vital in developing the relationships needed to develop and apply research findings to the delivery of medical and public health services in rural Arkansas. This article presents the development of a stress management intervention for the rural African American faith community.

SETTING

Mississippi County, Arkansas, is situated in Northeastern Arkansas in the Mississippi River Delta region. The African American population of the county is higher (33.7%) than in other counties in Arkansas.¹⁴ Between 2008 and 2012, 24.2% of families were below poverty level far higher than the state average of 18.7% and the average of 14.9% for the United States.¹⁴ The rate of depression in the county was not available, but according to the *Morbidity and Mortality Weekly Report*,²⁹ the prevalence of any type of depression in Arkansas is 12.0%, which is also higher than the national average. Mississippi County has 131 faith-based organizations with a total of 31,145 adherents.³⁰ These faith-based organizations primarily represent Baptist congregations, but Pentecostal, Methodist, Presbyterian, and nondenominational congregations are also among them.³¹

Through the UAMS Community Engagement Core program manager, a key informant in Mississippi County, Arkansas, with interest in depression among African Americans was identified. This key informant, an employee of the Blytheville Growing Healthy Communities Coalition, then organized a meeting with several other community leaders and interested parties in Mississippi County, including church and not-for-profit agency leaders and community advocates, to discuss a potential collaboration. At that time Johnny Moore, Jr., director of the Progressive Life Center, agreed to partner with the academic research team as a community leader and guide to develop a depression intervention. The nonprofit Progressive Life Center serves as an outreach ministry of PromiseLand Church of God in Christ, which is pastored by the Reverend Johnny Moore, Sr. The center is located immediately behind the church. The organization's purpose is to address the socioeconomic needs of families in Mississippi County.

FORMATIVE RESEARCH

In the fall of 2011, a series of six focus groups (24 participants) were conducted in Mississippi County with pastors, parishioners, and African American men with a history of stress or depressive symptoms.^{32–34} A male-only cohort was convened to determine whether the needs of African American males would require a gender-specific intervention. The aim was to gain an understanding of rural African American community perspectives on depression and ideas for eliminating depression disparities among rural African Americans, as a basis for developing a faith-based depression intervention targeting individuals in the rural African American faith community.³³ The focus groups identified key aspects of an intervention to address depression. Major needs identified included needs for 1) tools to help parishioners manage their stress, 2) education for the faith community about how to recognize and seek help for depression, 3) confidentiality and privacy in seeking mental health services, 4) training of lay leaders in the church to be “depression experts,” and 5) finally, given the stigma associated with depression, use of a term such as stress or something less threatening rather than calling an intervention a “depression intervention.” Other studies have also found that African American populations described depression as “stress” or “a funk.”^{35–37} The focus group participants said that the intervention did not need to be different for men and women, but should be delivered separately for the two groups, both to provide opportunities for male bonding and to address gender-specific issues.

Further, African American men's responses to depression depended on individual and contextual factors, suggesting the importance of taking into account cultural factors and gender in developing an intervention for depression in African American men. Last, the roles that language, reliance on the religious community, and masking of depressive symptoms by other medical conditions, somatic complaints, and substance abuse play in MDD.^{19,20}

Development of the Trinity Life Management Intervention

The Trinity Life Management intervention is based on the theory of self-efficacy³⁸ and on Social Network Theory.³⁹ The theory of self-efficacy states that efficacy expectations affect behavior, motivational level, thought patterns, and emotional reactions to any situation.³⁸ Self-efficacy expectations are beliefs in the capability to perform a specific behavior. Based on this theory, the intervention incorporates core self-management skills to strengthen self-efficacy, including problem solving, decision making, resource utilization, forming of a patient–health care provider partnership, and action taking.^{38,40} Research has demonstrated that self-efficacy is important for effective disease self-management.^{41–43} The ultimate goal is for persons to maintain or obtain a state of positive mental functioning, resulting in productive activities, fulfilling relationships, and the ability to adapt to change and cope with adversity.⁴⁴ Social Network Theory takes into account the social relationships surrounding individuals and their effects on individuals' health behaviors and health. Networks exert influence directly, indirectly, and interactively. Their influence is grounded in social norms, relationship characteristics, and the base of power.⁴⁵ These three factors interact to assist individuals within social networks to improve their coping resources and health behaviors.³³ The theory provides a framework for harnessing the power of social relationships to increase coping self-efficacy, which in turn should reduce perceived stress, psychological distress, and depression.

As noted, religious communities often provide mental health support to individuals in rural areas, where service shortages are common. In a recent study, high depression literacy was associated with greater perceived need for and use of religious leaders for help with men's mental health issues.¹⁷ Given the links among health literacy, culture, and religion in rural African American communities, interventions that address depression for this population should take these into account.

Stage 1. Creation of the Intervention Prototype

The content and structure of the collaboratively developed intervention was based on a) the focus group results,³⁴ b) evidence-based programs (e.g., the Chronic Disease Self-Management Program), c) evidence-based stress management techniques,⁴⁶ and d) national recommendations and guidelines (e.g., the National Institute for Mental Health, the American Lung Association). Based on the community's input, the focus of the intervention was refocused from depression to a stress–distress–depression (impairment) continuum^{47,48} with the aim of providing parishioners the self-management tools and techniques they need to effectively cope with stress. On this continuum, the state of a person's mental health depends on the amount of stress/distress and impairment involved. The lines separating states of mental health are not precise because it is not clear at which point a concern

becomes a problem, or a problem becomes an illness. The goals of the intervention are thus 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' self-efficacy for performing stress self-management behaviors when faced with life challenges.

The research team developed a faith-based stress management intervention prototype, designed to be implemented in gender-specific, small group settings to encourage peer support and provide parishioners the tools and techniques they needed to cope with stress and minor depressive symptoms. A workbook provided a holistic approach to the stress–distress–depression continuum, coping, and wellness. The workbook included scriptures, other Biblical references, and homework assignments, on self-reflection, goal setting, and the evaluation of goal attainment and modification. The assignments allow participants the option to keep their “personal business” confidential, and participants could avoid sharing “personal business” while learning self-management techniques for stress management and healthy living. The research team developed vignettes on common life circumstances such as family conflicts and financial difficulties to allow participants to discuss life issues and problems without sharing their own situations. Each vignette was followed by questions for group discussion about the fictional characters' experiences and their responses to life circumstances. The intervention was to be led by a community/lay person, because individuals are more likely to select programs delivered in their own communities by individuals of their own racial background. Additionally, the lay person delivery model supports sustainability.⁴⁹ Finally, because of the stigma associated with depression, the intervention focused on “stress” management rather than “depression” management, although many of the self-management techniques are the same for stress and minor depressive symptoms. In addition, information about when and where to seek mental health services was incorporated for those for whom self-management techniques would not be enough.

Stage 2. Development of a CAB

In the summer of 2012, a CAB was then engaged to collaborate with the academic research team in the refinement of a culturally appropriate depression intervention that would meet the specific needs of the community. The CAB consisted of persons identified by the lead author through personal contacts, participation in focus groups, or recommendation by the community leader, Johnny Moore, Jr. All members were dedicated to improving the health of their community and felt that the faith community should play a significant role. The CAB members represented clergy, a primary care physician, a mental health counselor, a registered nurse, and persons from the faith community interested in the health of their congregations. Members included Mr. Moore, who had recruited participants for the focus groups, and five persons who were participants in those groups. Some members had experienced a mental health disorder. All CAB members either resided and/or worked in Mississippi County. This was the first project that the CAB members had worked on together as a group, but many of them knew each other. The CAB confirmed that the intervention prototype (language, session topics, vignettes, resources) met the needs of the

community and was culturally appropriate. In addition, the CAB integrated spirituality, faith, and Biblical principles.

Stage 3. Refinement of the Intervention Prototype by CAB

The CAB met monthly with the academic team for 6 months to provide guidance in refining the intervention prototype. The CAB also provided valuable input into participant recruitment procedures, recruitment materials, and the location of the intervention sessions. To encourage participation by diverse denominations, the CAB recommended connecting with the local interfaith pastoral alliance. This would also provide an opportunity for pastors to hear about the intervention and to obtain their buy-in. The CAB named the intervention “Trinity Life Management,” representing the Holy Trinity—the Father, the Son, and the Holy Spirit—and the mind, body, and emotions. The CAB felt the intervention would help participants manage not only stress, but life in general; thus the name, Trinity Life Management. Last, the CAB suggested that the recruitment flyer should include pictures of families and adults smiling and appearing happy. They suggested either having a local contact on the flyer or using the flyer primarily for information purposes for CAB members to use when talking to parishioners.

The CAB also suggested the Health Trinity Model as a framework for delivery of the intervention to a rural African American faith community. This model shows the connections between the mind, body, and emotions, with the spirit as the core and flowing throughout. The model also shows how balance is needed to maintain wellness. Additionally, the CAB reviewed and revised the vignettes drafted for the intervention to ensure cultural appropriateness of minor details such as the names of the vignette characters as well as the challenges and obstacles the characters faced. Their suggestions were incorporated to ensure the situations were relatable. Finally, the CAB provided input on the design of the Trinity Life Management workbook, including gender-specific versions with pictures that each group could identify with; for example, the male version includes pictures of African American men and men’s health information. One CAB member and his family posed for some of the pictures in the workbook. Before finalizing the intervention workbook, content experts (psychologists and sociologist) reviewed the materials for accuracy and completeness.

Stage 4. Trinity Life Management: A Faith-Based Stress Management Intervention

The faith-based stress management intervention is a 6-week, gender-specific group intervention for people from the rural African American faith community. It is led by lay health leaders, called Trinity Leaders. The aim of the intervention is to teach stress management techniques and help participants to individualize these strategies to cope with stress. Participants work on goal setting and evaluation in relation to each topic. In addition, they acquire tools to achieve effective communication and self-reflection, and learn about the stress–distress–depression continuum and how it relates to the spirit and faith.

The intervention is conducted weekly for 6 weeks. The 90-minute sessions take place in small, gender-specific groups at a local church. All sessions of the intervention follow a similar format: they 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), this week's lesson(s), and a closing prayer. The weekly sessions cover the following topics from the Trinity Life Management workbook.

Chapter 1—"Stress Management and working with God" provides an overview of the "Health Trinity Model" in which the spirit is the core, flowing through the mind, body, and emotions, which are interconnected and make up a person. The chapter emphasizes the need for balance is essential to maintain wellness, and notes that stress in any part of the person can cause imbalance.

Chapter 2—"The Stress–Distress–Depression Continuum" discusses mental health and provides definitions of stress, distress, and depression. The chapter gives an overview of stress and how it is linked to depression. It provides participants information about causes, signs and symptoms, diagnosis, and treatment of stress, distress, and depression.

Chapter 3—"My Body Is a Temple: Exercise" provides information on how exercise can be used to decrease stress and on the importance of treating one's body as God's temple.

Chapter 4—"My Body is a Temple: Nutrition/Eating Healthy" 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 when stressed.

Chapter 5—"My Body is a Temple: Preventive Healthcare" provides an overview of measures to maintain wellness through preventive efforts. The chapter emphasizes that stress can have a negative impact on the body and may lead to hypertension or other health problems.

Chapter 6—"Communication" describes how communication with oneself, God, and others, including health care providers, can impact the Health Trinity. It also provides tips for effective communication.

Chapter 7—"Feelings and Emotions" explains how the mind differs from the 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 provided.

Chapter 8—"Balancing and Maintaining the Trinity" brings together all of the information in the previous chapters to aid in maintaining what has been learned.

Chapter 9—"Resources" includes local and regional social and health resources.

Stage 5. Trinity Leaders Training Material Development

Because the intervention is led by lay health leaders, Trinity Leaders, it was essential to develop training for these leaders. The training is based on The WORD (Wholeness, Oneness, Righteousness, Deliverance)⁵⁰ and includes both group and self-study activities delivered in modules. PowerPoint presentations, computer programs, group discussions,

reading assignments, and role playing are used to deliver the training. The CAB felt it was important for persons chosen as Trinity leaders to have knowledge of the Bible and experience in leading groups (Bible study, Sunday school), and to be respected in the community. Because the intervention is delivered in gender-specific groups, it was also necessary to identify both men and women to lead the sessions. The training includes information on skills that foster group activities, co-leading, and being nonjudgmental. Additionally, leaders are educated on the stress–distress–depression continuum, the connection between faith and health, and behavioral strategies to manage stress. Because of the potential for encountering participants with suicidal thoughts and ideations, the training also includes ways to handle these situations, and protection of human subjects, using the Collaborative Institutional Training Initiative online training.

CHALLENGES AND LESSONS LEARNED

A major challenge in the community–campus partnership has been distance. Mississippi County is located approximately 185 miles from the university campus. Because of this distance, it was challenging for research team members to build rapport with community members. However, various means of communication were used such as email, text, and telephone, and physical presence with the community at least every month or two was crucial to maintain the relationship.

Also, the research team harbored some preconceived ideas about the rural faith community. For example, the fact that pastors are often bivocational was not considered fully when beginning the engagement process. Finding times to meet with pastors and develop an effective intervention with them was challenging because of their dual responsibilities to employers and the congregation. Additionally, it was assumed that, because of the shared beliefs of Christian congregations, all would be willing to come together for a common cause. Community members clarified that although this is desired in theory, in reality some churches are territorial and do not want to share assets and resources. As the relationship developed, the research team’s ideas about the faith community changed, and they gained a better understanding and appreciation for the community’s assets, culture, and beliefs.

After participating in the intervention development, the attitudes and understanding of health of some CAB members also changed. They said they learned how to incorporate exercise and stretching into daily activities and they had a better understanding of mental health. One of the pastors said that the health information he learned influenced some of his sermons. Another CAB member said he had not known how much time, energy, and thought it took to develop a research intervention. He found a new appreciation for this and felt proud to be a part of the intervention’s creation. Although CAB members were not able to attend all of the meetings, their insights were invaluable for intervention development.

Last, the shift to a stress–distress–depression intervention was not anticipated by the research team. The stigma attached to depression and other mental illnesses is an on-going challenge and may explain the lack of evidence-based depression interventions in the African American faith community. Other studies^{20,34,51} have noted the stigma of depression among African Americans and rural communities. Even some CAB members

expressed beliefs depression is a sign of weakness or caused by demons. Conflicts between CAB members and the academic team did not occur, but it is unclear whether these views were changed after involvement in intervention development.

CONCLUSIONS

Many CBPR principles were used in this development of the intervention, including recognizing the community as the unit of identity, building on community strengths and resources, and facilitating of co-learning and capacity building. The collaboratively developed Trinity Life Management intervention is designed to meet the needs of the rural African American faith community while providing an opportunity for community empowerment and capacity building of community partners. The lay health leader design enables community members to lead the intervention, promoting community leadership, and increases lay leaders' knowledge of the stress–distress–depression continuum and stress self-management skills. Last, engagement and collaboration with the community have led to incorporation of community priorities, which help to support longevity and sustainability of the intervention after the conclusion of the research.

As with any community-engaged study, much time and energy were required to build trust. For the Trinity Life Management intervention, additional time and commitment were needed for the intervention development. A major concern of the CAB was whether the community would be ready to receive information on stress–distress–depression and be willing to make changes in their lives. A feasibility study of the Trinity Life Management intervention will now be conducted in the community to “test” the intervention materials, but also recruitment strategies, intervention sites, and community readiness. The academic team and community members are both committed to long-term efforts to decrease the experience of depression among rural African Americans.

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