



A pilot randomized trial teaching mindfulness-based stress reduction to traumatized youth in foster care



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ABSTRACT

This article presents a pilot project implementing a mindfulness-based stress reduction program among traumatized youth in foster and kinship care over 10 weeks. Forty-two youth participated in this randomized controlled trial that used a mixed-methods (quantitative, qualitative, and physiologic) evaluation. Youth self-report measuring mental health problems, mindfulness, and stress were lower than anticipated, and the relatively short time-frame to teach these skills to traumatized youth may not have been sufficient to capture significant changes in stress as measured by electrocardiograms. Main themes from qualitative data included expressed competence in managing ongoing stress, enhanced self-awareness, and new strategies to manage stress. We share our experiences and recommendations for future research and practice, including focusing efforts on younger youth, and using community-based participatory research principles to promote engagement and co-learning.

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1. Introduction

There are over 400,000 children in foster care in the United States on any given day, of which 46% are youth aged 11–20 years [8]. This growing sector of children in out-of-home care represent some of the most challenging youth in the system today, many of whom have experienced removal from birth homes due to abuse, neglect, parental health and mental health morbidity [28], and have encountered multiple placements [38] and/or failed adoptions. Research shows the impact of multiple disruptions on children and youths' emotional well-being and academic performance [12,13,26,36]. Youth in foster care are often minimally engaged in school [47], and have disproportionately higher rates of mental health problems [10,21,30,45], and are at higher risk from suffering

from chronic health problems [1]. The longitudinal impact of early exposure to childhood adversity and the later development of chronic, unmitigated health morbidity in adulthood [14] has highlighted the import of toxic stress, further supporting the importance of early identification and treatment of early childhood social-emotional problems [10,20].

Research on youth has demonstrated the value of extra-curricular activities and the positive impacts on contributing to interpersonal competence, lower levels of depression and enhanced academic achievement [33,34]. Using a nationally representative sample in the National Survey of Child and Adolescent Well-Being, Conn et al. examined 134 youth in out-of-home care, and found that only 40% were involved in structured activities, and that participation was lowest for racial/ethnic minorities and males [11]. This paper highlighted the importance of structured (i.e. organizations, clubs, teams, or groups) vs. unstructured activities (physical activities such as bike riding, swimming, basketball, etc.), and found that while youth involved in both structured and unstructured activities demonstrated greater social skills and fewer symptoms of drug abuse, those who were in structured activities

Abbreviations: PSC, Pediatric Symptom Checklist; STAIS, State-Trait Anxiety Inventory for Children; CAMM, Child Adolescent Mindfulness Measure.

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reported less loneliness and fewer symptoms of drug abuse and depression. This finding is important, and serves as important rationale for the pilot study proposed in this paper, which hypothesized that involving youth in foster care in formal activities with other similar youth would build social skills and also decrease mental health morbidity.

Our pilot project proposed to use a novel approach to helping youth in foster care, many of whom have experienced early childhood adversity, to manage stress. The use of stress-reduction techniques is not the traditionally accepted treatment for traumatized youth experiencing internalizing symptoms. Because many such youth are noncompliant with treatment recommendations, we have previously explored alternative options that consider youth acceptance of mental health treatment. In a qualitative study of both foster parents and foster youth, we explored perceptions on mental health care for traumatized youth. Key findings from these home-based in-depth interviews were the double stigma of being in foster care and of getting mental health care, and the willingness of youth to seek group-based mental health therapy among similar peers, and also mental health care that is integrated with their primary care practice [24]. These findings have provided the basis for innovative group-based models of care, such as what we proposed with mindfulness training in this project. Others have cautioned against deviant peer clustering, that may amplify in group-based settings, especially during late adolescence [46]. Mindfulness is an evidence-based approach [27] that has been tested in some select child and adolescent populations [4,6,32], but to our knowledge, not specifically for youth in foster and kinship care with this type of group setting.

In Rochester (NY), we have an ideal environment to study the use of an evidence-based stress-reduction curriculum delivered in a group format to high-risk youth in foster and kinship care. Starlight Pediatrics, which is a pediatric medical home (clinic) for children in foster care (~700 children annually), is nationally recognized as a model of care [40]. The patient population is demographically comparable to that seen nationally in foster care, which makes study findings potentially generalizable to a national population. Our research has implemented systematic, primary-care based developmental [20] and social-emotional [20–22,24] screening at Starlight Pediatrics. This study sought to provide an alternative exploratory approach to coping with the stress associated with multiple disruptions utilizing a group approach with youth in foster care. This pilot RCT project had the following objectives: 1) to measure baseline stress among a group of youth in foster; 2) to design and implement a pilot program to target stress-reduction by adapting an evidence-based group therapy technique that has not been applied to foster care; and, 3) to measure impact on stress using psychological and physiological techniques.

2. Data collection and methods

2.1. Setting

Weekly groups for teens in foster care and kinship care were held in shared conference room space, co-located with the family visitation center, and the pediatric clinic dedicated to the care of children in foster care. Starlight Pediatrics, located at the Monroe County Health Department in Rochester NY, is a primary care pediatric practice that serves as the medical home for all children in family-based foster care in Monroe County, NY (700 children, 3400 visits per year). All children and youth in family-based foster care attend this health clinic, so the location of the weekly teen groups was accessible to youth and their families.

The University of Rochester Research Subjects Review Board approved the study.

2.2. Subjects and recruitment protocol

Our pilot RCT project was comprised of two groups of teens, in which we had intervention and control groups (target $n = 10$ –12 youth) for both the fall 2012 and spring 2013. In September 2012, our research team posted flyers advertising weekly teen groups at Starlight Pediatrics. We also sent out informational letters to foster parents and caseworkers inviting youth in foster care and supervised kinship care, aged 14–21 years ($n = 92$), to participate in a weekly group focused on stress reduction and promoting social skills. Youth were also referred by their caseworkers, and our research team made follow-up phone calls to youth and families to recruit for this program. The proposed program was a weekly program for 10 weeks that would teach stress reduction skills, but also offer the opportunity to have dinner and socialize in a supervised environment with other youth in foster care and kinship care.

Prior to the first session, we collected a list of interested youth, and we randomized youth to be in either the intervention group (attending 10 weekly sessions and comprised of an eight week mindfulness intervention program, and completing pre- and post-evaluation measures on the first and last sessions) or the control group (completing pre- and post-evaluation measures on the first and last sessions). We aimed to recruit 20–24 youth for each 10 week session, so we would have no more than 12 youth in our intervention group. Based upon our previous experience and recent focus groups to determine the optimal way to set up our groups, we limited our group size in order to maximize the opportunity for youth to feel comfortable with a consistent group of similar youth. We used a table of random numbers to order sealed envelopes which included the names of the participants who indicated by phone confirmation they were coming to the first group. We randomized youth by age and gender, but the subjects were blinded to the group for which they were randomized (i.e. intervention or control group). This information was released at the time of the first session (to complete the pre-evaluation measures). This strategy was adopted in order to avoid any bias in our groups due to stronger motivation to participate in the weekly program. All youth (intervention and control groups) received \$25 each time they completed the evaluation measures (\$50 total for both pre- and post-evaluation measures). We made every effort to treat our intervention and control groups comparably, and we offered them identical incentives for completion of evaluation instruments, and food at the time of completing the evaluation.

All participants reviewed and signed the IRB- approved consents (if > 18 years) or assents (14–17 years), and DHS provided administrative consent for participation in the program. Consents had very detailed information about the questions in the evaluation measures. The participants were informed that they could withdraw from the study at any time, and their participation was voluntary. Further, prior to each assessment (quantitative, qualitative, and ECG monitoring), our research assistants reviewed the protocol and the consent with participants.

Youth in the intervention group could receive an additional \$50 for attending all 10 sessions (total of \$100 for attendance and completion of evaluation measures). Youth in session 1 (fall 2012) not randomly selected for the intervention (weekly group) were told that they were still eligible to participate in the spring 2013 group. We were unable to make our control group a weekly group that did not teach mindfulness skills because we did not have adequate space or staffing. We did not want to “contaminate” our program with some specific exposure to mindfulness or social skills at the time they were completing the pre- and post-evaluation measures. We did, however, randomize youth to be in the same “arm” of the study if more than one youth were in the same foster home, or if they were siblings, because we anticipated that

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