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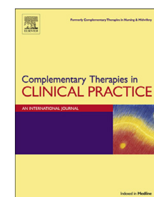

Mindfulness based stress reduction adapted for depressed disadvantaged women in an urban Federally Qualified Health Center

Inger E. Burnett-Zeigler [a, *], Maureen D. Satyshur [a], Sunghyun Hong [a], Amy Yang [a], Judith T. Moskowitz [b], Katherine L. Wisner [a]

[a] Northwestern University, Feinberg School of Medicine, Department of Psychiatry and Behavioral Sciences, Chicago, IL, USA
[b] Northwestern University, Feinberg School of Medicine, Medical Social Sciences, Chicago, IL, USA

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ABSTRACT

Background: In this study we examine the feasibility and preliminary effectiveness of mindfulness based stress reduction adapted for delivery in an urban Federally Qualified Health Center (FQHC).
Methods: Thirty-one African- American adult women ages 18–65 with depressive symptoms enrolled to participate in an 8-week mindfulness group intervention. The primary outcome (depression) and secondary outcomes (stress, mindfulness, functioning, well-being, and depression stigma) were assessed at baseline, 8 and 16-weeks.
Results: Depressive symptoms significantly decreased from baseline to 16 weeks. A significant decrease in stress and significant increase in mindfulness was found from baseline to 8 weeks and baseline to 16 weeks. Additionally, aspects of well-being—self-acceptance and growth—significantly increased from baseline to 8-weeks. Stigma significantly increased from baseline to 8 weeks and significantly decreased from 8 to 16 weeks (all p's < 0.05).
Conclusions: Mindfulness-based interventions implemented in FQHCs may increase access to effective treatments for mental health symptoms.

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1. Introduction

Depressive disorders are among the most common psychiatric disorders with 12-month prevalence estimates ranging from 5 to 10% for Major Depressive Disorder (MDD) [30,31,38,39,41,59] and 2–5% for Dysthymic Disorder (DYS) [39,41,59]. Women [38,41] and disadvantaged individuals such as those who are unemployed, with less education and income, and public or no insurance are at increased risk for having had a depressive episode in the last year [30,31,38,41]. An estimated 40–60% of individuals with depressive disorders do not receive treatment [30,38,78]. The disparity between individuals with psychiatric needs versus those receiving treatment is in part attributable to negative attitudes toward traditional mental health treatment, concerns about stigma and embarrassment [25,28,51] and mistrust of the mental health system [51]. Disadvantaged individuals are more likely to hold stigmatizing beliefs and negative attitudes toward mental health treatment [17,48,51] and less likely to receive treatment [40,46,53,78].

The majority of those who do receive depression treatment receive it in primary care, rather than specialty mental health clinics [38,40,42,78]. In primary care, antidepressants are the most commonly offered depression treatments, however adherence is poor (40%–75%) [54], the response rate (60%) is low [76], many do not consider antidepressants acceptable treatments (Lisa A [19]. or prefer to be treated without medication [22,24,29,58,77]. Studies on treatment preferences for depressed primary care patients have found that 33–80% of respondents report concern about the undesirable side effects of medication and addiction [77]. African-Americans and Hispanics are less likely than Whites to find antidepressants acceptable and more likely to hold negative beliefs about antidepressants (Lisa A [19,24]. Depression treatment co-located in primary care settings likely facilitates greater access to care for those who are unlikely to go to specialty mental health. However, offering patients treatments that are inconsistent with their preferences is associated with failure to initiate treatment, poor adherence and early discontinuation [2].

Mind body (MB) complementary and integrative approaches

* Corresponding author. 676 N. St. Claire, Suite 1000, Chicago, IL, 60611, USA.
E-mail address: i-burnett-zeigler@northwestern.edu (I.E. Burnett-Zeigler).

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(CIA) such as meditation (including mindfulness), movement therapies, relaxation (breathing exercises, guided imagery, progressive muscle relaxation) and yoga are among the most commonly used CIAs and they continue to increase in their popularity [9]. Despite overall lower rates of using MB approaches among racial/ethnic minorities (14.8% African-American versus 21.4% White) [9], significant proportions of racial/ethnic minorities use CIAs as health treatments [7,8,10,11,49] found that 69% of African Americans in the general population used CIAs (including prayer) in the last 12 months [7,8]. A study of underserved African-American and Hispanic patients in primary care found that 24–33% reported using CIAs for the treatment of depression; of those that used CIAs, 47% used MB approaches. In this study, patients without health insurance, moderate depression, using psychiatric medication and poorer self-reported health status were more likely to use CIAs [10].

Mind body approaches to depression treatment co-located in primary care may be more accessible and acceptable than conventional mental health treatments among disadvantaged individuals [4,7,8,10,72,79] suggests that individuals who believe in the importance of body, mind and spirit in treating health problems are more likely to use alternative medicine [4]. African-Americans report spiritual beliefs and practices are an important part of coping with illness [18,34] and believe in the power of spirituality to promote healing [34]. In the 2002 National Health Interview Survey, 67% of African-Americans reported using prayer for their own health [26]. It is likely that mind body approaches to healthcare are culturally synergistic with the worldview of African-Americans who already incorporate spiritualty into coping with and treating illness [4]. also found that those who distrust conventional physicians and desire control over their own health are more likely to rely on alternative forms of medicine [4]. African-Americans report higher levels of medical mistrust than other race/ethnicities [14]. Additionally, African-Americans who report more instances of racial discrimination in medical and non-medical settings are more likely to use CIAs [68]. African-Americans may perceive alternative health approaches that can be employed independent of medical professionals as more acceptable than conventional medicine. Finally, individuals who experience problems accessing healthcare [37] or find conventional healthcare is too expensive [9,26,52,74] are more likely to use CIAs.

Mindfulness meditation involves intentionally paying sustained attention to ongoing sensory, cognitive and emotional experiences without elaborating or judging any part of that experience [35]. Mindfulness based interventions have collectively been shown to improve physical and mental health [5,43,55] and have at least medium-sized effects (Cohen's d = 0.5–0.6) [5,27,33,43]. Few studies have examined the effectiveness of mindfulness based interventions among disadvantaged populations. A meta-analysis of acceptance and mindfulness based interventions with underserved populations (N = 35) found small to large effect sizes (Hedges' g range 0.38–1.32). Studies that included no-contact or waitlist condition demonstrated the largest effect size (g = 1.32), followed by studies that used an active treatment (g = 0.67) and studies using a pre-post design (g = 0.57). Of the 35 studies reviewed, 8 evaluated MBSR or MBCT and 5 of those 8 studies were with disadvantaged populations (racial/ethnic minority, urban youth, forensic). In 3 of the 5 studies, participation in a mindfulness based intervention was associated with significant pre-post changes in reported psychological outcomes [23]. This review highlights the paucity of research examining the effectiveness of mindfulness based interventions among disadvantaged, racial/ethnic minority adult populations.

One of the most widely used mindfulness based interventions is Mindfulness Based Stress Reduction (MBSR), an 8-week group intervention that teaches mindfulness skills through a range of formal and informal mindfulness practices including mindfulness of breath, bodily sensations, sounds, thoughts and everyday activities. The few studies that have been conducted about use of MBSR among disadvantaged individuals report program completion rates higher than those of other evidence based treatments [21,32,61]. Additionally, participants believe the skills they acquire are important, they are willing to practice MBSR techniques on their own, even after the intervention ends and they state that mindfulness became an integral part of their lives [12,21,61]. Preliminary research suggests that mindfulness based interventions are efficacious in reducing mental health symptoms [1,13,67,70,71] and improving general health [45,57,60–62], daily functioning, interpersonal relationships and overall quality of life among disadvantaged individuals [12,21,32,47,69–71].

Mindfulness based interventions provided within primary care may be an important depression treatment alternative for individuals of lower socioeconomic status and racial/ethnic minorities who are less likely to access conventional mental health treatment. Mind body approaches are utilized among disadvantaged populations and use of these interventions is associated with positive psychological outcomes. However, little is known about the effectiveness of mindfulness based interventions among disadvantaged, racial/ethnic minority populations in the primary care setting. The aims of the present study were to: 1) Evaluate feasibility of recruitment, enrollment and retention in a mindfulness based intervention for depression delivered to disadvantaged women in a FQHC and 2) Generate preliminary data on the distribution and variability of the primary outcome, depression and secondary outcomes mindfulness, stress, functioning and well-being. The limited literature suggests that participation in a mindfulness based intervention is likely to affect these outcomes. The overarching hypotheses are 1) Rates of enrollment and completion will be greater than those reported in the literature for conventional mental health treatments; (2) Participation in the intervention will be associated with increased mindfulness, well-being and functioning and decreased depression and stress. We believe that participation in a mindfulness based intervention is likely less stigmatizing than participation in a conventional mental health treatment. Therefore, we will also assess change in depression stigma as a secondary outcome.

2. Methods

2.1. Setting and study population

Adult women were recruited from the Near North Health Services Corporation (NNHSC) Clinic, a group of Federally Qualified Health Centers (FQHCs) in Chicago. The NNHSC consortium includes nine clinics that have approximately 46,130 patient visits per year; the majority are uninsured (58.86%) and living at or below the poverty line (74%). The study was discussed with all of the NNHSC healthcare providers. The study was also advertised via brochures and posters in the clinic. Brochures and posters listed symptoms including feeling "stressed, overwhelmed, irritable, difficulty concentrating, unmotivated, tense, tired or fatigued" that helped potential participants identify themselves as potentially eligible. The healthcare providers provided a brief overview of the study and gave a brochure to all female patients between 18 and 65 years of age who presented with depressive symptoms during a regular healthcare visit. Potential participants were also recruited by the PI or RA from the waiting room or self-referred.

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