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"Maybe black girls do yoga": A focus group study with predominantly low-income African-American women

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ABSTRACT

Objective: To explore African American (AA) women's use of mind-body therapies, such as yoga and mindfulness, and factors that impact their experiences, observations and opinions.
Design: Focus groups were conducted to better understand how AA women perceive mind-body therapies and how to best bring these interventions into their community. Interviews were audiotaped and transcribed.
Setting: The urban Midwest.
Outcome measures: In addition to qualitative outcomes, descriptive measures included the Perceived Stressor Scale, Beliefs About Yoga Scale, and Determinants of Meditation Practice Inventory (DOMPI).
Results: Twenty-two, predominantly low-income (75% reported income < $50,000) and single (82%) women participated in three age stratified focus groups (18–34 years, 35–65 years, 66 years and older). Participants acknowledged life stress and shared common coping mechanisms. They recognized that yoga and mindfulness could be beneficial and discussed barriers to practice (including personal and structural). Younger women reported more time constraints as barriers, middle aged women had more experience with yoga, and older women identified the spiritual component to yoga/mindfulness as potentially conflicting with current coping strategies. Participants suggested ways to share mind-body therapies within the AA community along with solutions for engagement.
Conclusions: AA women acknowledged stress in their lives and recognized the need for additional coping measures. Although women reported interest in yoga/mindfulness they identified barriers, including limited access to convenient classes, and offered suggestions for bringing yoga and mindfulness to their communities.

1. Introduction

Compelling evidence suggests that chronic stress contributes to multiple health conditions, such as cardiovascular disease and diabetes.[1] Compared to non-Hispanic White (NHW) women, African American (AA) women experience a higher burden of morbidity and mortality related to stress-related diseases. For example, the death rate for AAs is 37% higher than for Whites and the risk for having a first-time stroke is almost two times greater for AAs than for Whites.[2] Cardiovascular health disparities emerge by middle age, exist across all socieconomic levels, and are not fully explained by traditional risk factors such as obesity, hypertension, and diabetes.[3–5] Increasing evidence links the social and cultural context of life experiences and poor health outcomes.[6] Mind body therapies, such as mindfulness based stress reduction (MBSR) and yoga, have been shown to reduce chronic stress, decrease inflammation[7] and improve overall well-being.[8–11] These therapies are considered to be complementary and alternative medicine (CAM) or complementary health approaches, defined as therapies that are not presently considered to be part of conventional medicine.[12]

Although only a few studies have examined the effectiveness of CAM in minorities, evidence suggests that mind-body interventions reduce stress[13] and improve health[14] in AAs. For example, in a randomized clinical study of predominantly AAs with heart failure, yoga provided additional benefits to standard medical care in terms of improved quality of life, better cardiovascular endurance, and decreased inflammation.[15] In another study of older AAs with hypertension, individuals who participated in an 8-wk mindfulness based stress reduction program had significantly lower systolic blood pressure as compared to those in a control group who received only social support.[16]

Evidence suggests that while CAM use is greatest in NHWs, approximately 26% of AAs in the United States use CAM therapies. While studies demonstrate that AAs have a strong interest in participating in CAM,[17–19] few studies have examined barriers to AAs utilizing CAM. For example, one study revealed that AA women felt that mindfulness was not congruent with their cultural beliefs.[20] Other studies have

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suggested that CAM use is more likely when access to traditional care is limited.[21] Therefore, there is a need to explore the acceptability of stress-management interventions that promote health through culturally relevant interventions.[6]

CAM therapies are increasingly relevant health care choices for women.[22,23] These may have the potential to provide relief from stress related health conditions. Researchers and clinicians recommend more evidence based science on mind-body interventions for AA women's social and cultural experiences of stress.[6] While little is known about the relationship between stress reduction and CAM use in AA women, clinicians and researchers are designing holistic interventions to encourage communities to self-manage their health and wellness needs. The purpose of this study was to explore AA women's attitudes, opinions, and beliefs about CAM use to allow for better design and tailoring of CAM interventions to the needs of AA women.

2. Methods

This qualitative study was approved by Loyola University Chicago Institutional Review Board. Focus groups, stratified by age (18–34 years, 35–65 years, 66 years and older), were the primary source of data collection. The stratification provided a more homogeneous sample and allowed for minimization of the generational influence of age on CAM use. Women were recruited from the community, including park districts and community centers, and were eligible for study participation if they were English speaking and self-identified as African American. Current use of CAM was not required for inclusion criteria.

Prior to the focus group discussion, participants provided information about their demographics and completed the Perceived Stressor Scale (PSS).[24] The PSS is a reliable and valid (Cronbach alphas 0.75–0.86) 10 item measure that assesses the degree to which one finds life unpredictable, uncontrollable or overloaded over the past month. Women also completed two measures related to CAM use. The Determinant of Meditation Practice Inventory (DMPI) is a 17 item tool that assesses perceptions and misconceptions of meditation practice, with higher scores indicating more barriers to practice.[25] It has demonstrated reliability and validity with a Cronbach's alpha of 0.86. The Beliefs About Yoga Scale is a 11 item tool that assesses the expected health benefits, discomforts and social norms related to yoga practice, with higher scores indicating more positive beliefs.[26] The tool is reliable and valid, with Cronbach's alphas ranging from 0.62–0.83.

2.1. Data collection

Following written informed consent, women participated in age-stratified focus groups at local community centers. A team of female researchers who were experienced with qualitative research (LH) and with CAM interventions within the community (ST) led the study. Focus group sessions were audiotaped and field notes captured broad observations on participant characteristics, body language, and enthusiasm. The facilitators used a semi-structured interview guide created by the team (ST, LH, and KS) to elicit responses about life stressors and coping skills as well as familiarity with CAM therapies like yoga and MBSR. The interview guide contained open-ended questions such as "Talk about some of the problems women experience with stress and how it affects their health"; "Have you heard about MBSR and/or yoga"; and "Would you consider practicing MBSR or yoga? Why or why not?" The participants were encouraged to share personal experiences, guide the conversation to areas relevant to their life experiences, and discuss suggestions for bringing CAM therapies to the community and making sustainable programs.

Focus groups were conducted in private rooms within the community centers and typically lasted 30–60 min. Participants were provided with snacks and drinks, and encouraged to mingle to establish a feeling of comradery. All participants were compensated for their time with a $20 gift certificate.

2.2. Data analysis

Statistical analysis of quantitative data was carried out using IBM SPSS Statistics for Windows, version 24.0[27] and $p < 0.05$ was consider statistically significant. Data were analyzed for descriptive statistics and results between groups were compared using students *t*-tests. The qualitative discussions were audiotaped and transcribed verbatim. Descriptive validity (factual accuracy) and interpretive validity (data grounded in the language of the participants) was ensured by audiotaping the focus group sessions. After transcription, each member of the team independently read the interviews and field notes. Dedoose[28] software was used for the coding process and two members of the research team (ST and LH) independently generated the initial code lists from the reviewed the transcripts. Data was analyzed with inductive and deductive thematic analysis methods. Themes were generated from reviewing code frequencies and discovering broad commonality of themes. There were not dramatic differences between groups, except where highlighted in the themes below.

3. Results

Twenty-two women participated in the focus groups (see Table 1). Women who participated in this study were predominantly low-income, with 77% of the participants reporting average household incomes of less than $50,000. Women were mostly single (82%), college educated (68%), and had children (86%). All women who participated were attending a religious service at least monthly. Women in our study reported slightly higher than average stress (mean 15.6), reported minimal barriers to meditation (mean 38.2) and had neutral beliefs about yoga (mean 48.0). There were no statistical differences between the groups in their perceived stress, determinants of meditation or beliefs about yoga.

Five main themes arose from the focus groups: (1) conceptualization of stress; (2) responses to stress; (3) meaning and perceptions about yoga and mindfulness; (4) benefits/barriers to practice; and (5) suggestions and solutions for engagement.

3.1. Conceptualization of stress

The main discussions regarding the role of stress generated similar concepts between the three stratified groups. AA women saw stress as broadly including both family and community issues. Across the age groups, women were concerned for the health and safety of their children. For example, one participant described the struggle of wanting to

Table 1
Demographic Characteristics of Participants (n/[%]).

Variable	Total Sample (*n* = 22)	18–35 years old (n = 7)	36–65 years old (*n* = 10)	66 years old and over (*n* = 5)
Marital status				
Partnered	4 (18.2%)	0 (0.0%)	2 (20%)	2 (40%)
Divorced	6 (27.3%)	0 (0.0%)	3(30%)	3(60%)
Single	12 (54.5%)	7 (100%)	5 (50%)	0 (0.0%)
Highest educational level				
Less than college	7 (31.8%)	3 (42.9%)	2 (20%)	2 (40%)
College or more	15 (68.2%)	4 (57.1%)	8 (80%)	3 (60%)
Household income				
Less than $75,000	18 (81.8%)	6 (85.7%)	7 (70%)	5 (100%)
$75,000 or greater	4 (18.2%)	1 (14.3%)	3 (30%)	0 (0.0%)
Frequency of church or spiritual group attendance				
< once a month	15 (68.2%)	3 (42.9%)	7 (70%)	5 (100%)
> once per month	7 (31.8%)	4 (57.1%)	3 (30%)	0 (0.0%)

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