

A Qualitative Investigation of the Interaction between Religion and Culture and a Mindful Self-  
Compassion Intervention Among Communities of Color

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**Abstract**

A Qualitative Investigation of the Interaction between Religion and Culture and a Mindful Self-Compassion Intervention Among Communities of Color

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**Background:** Mindful self-compassion (MSC) is a new subset of mindfulness-based interventions that have been implemented among parents of children with special health care needs due to its positive psychological effects and ability to increase subjective wellbeing. Parents of color whom have children with special health care needs experience additional stressors when compared to parents of typically developing children given the social, economic, and psychological demands of caring of their children. This parent group can also endure added stressors compared to non-Hispanic whites, such as experiences of racism, discrimination, and/or anti-immigrant sentiment. **Study Aim:** We examined how cultural and religious beliefs or practices align and interact with the delivery of MSC interventions among communities of color caring for children with special health care needs. **Methods:** We analyzed qualitative data

collected in 2018 from participants (n=19) of the Finding Strength for the Long-Haul study. We used an inductive, constant comparison approach in which concepts were identified and themes derived from the interview data. **Results:** Overall, participants described alignment between MSC aspects and religion and mentioned how incorporating some MSC aspects into their religious practices enhanced their overall spiritual experiences. An unanticipated finding was shifts in religious and cultural perspectives experienced during the class. However, there were some MSC aspects and programmatic logistics that conflicted with religious and cultural beliefs and practices which negatively impacted participants experience with MSC. **Conclusion:** The findings of this study enriches the limited literature on the interaction between religious and cultural beliefs or practices and mindfulness-based interventions among communities of color. While MSC is known for its psychological benefits, it is important to understand the weight of religious and cultural beliefs on perception and receptivity of MSC to improve the content and the delivery of the MSC intervention.

## **Background**

Mindfulness-based programs have demonstrated beneficial mental health outcomes, such as reducing stress, decreasing depressive symptomatology, and promoting life satisfaction across diverse populations (Blum, 2014; Neece et al., 2019; Woods-Giscombé et al., 2014).

Mindfulness is an age-old Buddhist meditation that has been adopted and practiced typically as a secular concept in western culture over the past several decades. It is defined as paying attention to one's present moment experience as it is happening, and relating to this experience with a curious, open, and accepting attitude (Kabat-Zinn, 1994; Neff, K. (n.d.). Such an awareness avoids overidentification and disassociation with experience, allowing for a nonjudgmental and receptive mind state in which one's thoughts and feelings are observed for what they are, not in terms of how they impact one's self-concept. (Neff and Germer, 2013). Another Buddhist construct popularized in western culture is self-compassion in part due to its strong link to psychological health. Self-compassion involves being touched by one's own suffering, which generates the desire to alleviate our own distress and heal oneself with kindness. It involves offering nonjudgmental understanding to one's pain, inadequacies and failures, so that one's experience is seen as part of the larger human experience (Neff, K., 2003). The two concepts have since been combined to create a "hybrid" program referred to as Mindful Self-Compassion (MSC). The mindfulness component of self-compassion refers to balanced awareness of the negative thoughts and feelings derived from personal suffering. MSC has shown positive psychological effects, including increased subjective wellbeing, reduced negative symptomatology and emotional reactivity, improved behavioral regulation, and can help reduce anxiety and depression (Neff & Germer, 2013).

Recently, mindfulness-based interventions have been adapted and delivered for parents or caregivers of children with special health care needs (Neece et al., 2019). This parent group experiences additional stressors when compared to parents of typically developing children given the social (e.g., social isolation/ lack of social support), economic (e.g., financial strain), psychological demands (e.g., worry about their child's health and well-being) and efforts of caring for their children (Cousineau et al., 2019). Studies with parents in the US and outside of US show poor mental and physical health among parents of children with chronic health conditions, activity limitations, and disabilities (Cousineau et al., 2019; Bujnowska, Anna, et al., 2019; Davis, Naomi, and Ornstein Carter, 2008; Eisenhower, A., Baker, B., & Blacher, J., 2005; Valicenti-McDermott, Maria, et al., 2014). Furthermore, parents of color report higher stress compared to non-Hispanic whites, in part due to differences in economic resources, environmental factors (e.g., social networks and work/neighborhood conditions), and maternal and child characteristics (e.g., self-concept, health conditions, and behavioral problems) (Nam, Y., Wikoff, N., & Sherraden, M., 2015; Williams, David R., et al., 2010), and is often exacerbated by experiences of racism, discrimination, and/or anti-immigrant sentiment (Baum, A, et al., 1999; Karlsen, Saffron Y, and James Y. Nazroo, 2002; Phipps, R., & Degges-White, S., 2014; Woods-Giscombé, Cheryl L., and Marci Lobel, 2008). Yet, most mindfulness-based interventions have been conducted among predominantly non-Hispanic white populations (Blum, 2014; Cousineau et al., 2019).

Similar to studies among non-Hispanic whites, the majority of studies with culturally diverse populations have primarily focused on assessing the feasibility, efficacy, and acceptability of mindfulness-based interventions (Burnett-Zeigler, Inger, et al., 2019; Neece et al., 2019). However, what remains largely unexplored is how mindfulness interact with cultural

and religious beliefs (two key known factors among culturally diverse communities) among communities of color. A seminal qualitative study that examined the cultural relevance of a secular mindfulness-based stress reduction (MBSR) intervention among fifteen African Americans (whom most reported being Christian) found a number of similarities between mindfulness meditation and practices in African American culture (Woods-Giscombé et al., 2014). Prayer was the most commonly mentioned cultural practice as having similarities to mindfulness meditation, where participants cited religious text that promoted meditation, quietness, and being still (Woods-Giscombé et al., 2014). Malalignment of the mindfulness program content with religious beliefs were also noted when participants perceived that they were participating in another religion when an instructor accidentally mentioned Buddha (mentioning Buddha is not part of traditional mindfulness instruction), leading the participant to question the appropriateness of the class for her (Woods-Giscombé et al., 2014). Other studies have noted that that because mindfulness-based interventions (MBIs) can be a form of culture mixing, their association with religious values and beliefs may cause those with strong religious commitments to see them as infringing upon sacred elements of their culture (Palitsky et al., 2019). This demonstrates the weight of religious and cultural beliefs or practices on receptivity and perception of MSC and needs to better understand the interaction between religious and cultural beliefs and MSC among culturally diverse populations. The purpose of this study is to examine how cultural and religious beliefs or practices align and interact with the delivery of MSC interventions among communities of color caring for children with special health care needs.

## **Methods**

This study is a secondary analysis of qualitative data collected from January- September 2018 from the Finding Strength for the Long-Haul MSC intervention that was delivered secularly among caregivers of children with special health care needs. The curriculum for this program was adapted from Kristin Neff and Chris Germer’s original MSC curriculum, who were the first to develop and evaluate MSC programs (Neff & Germer, 2013). The program aimed to provide experiential learning opportunities to explore mindfulness and self-compassion with a focus on skill building that may be used by caregivers in their daily life. Participants were parents or caregivers of children with special health care needs from diverse cultural and religious backgrounds. The intervention was developed in collaboration with a diverse racial/ethnic group of parents to tailor the content for cultural appropriateness for parents with minimal mindfulness experience, and whom might speak English as a second language.

The intervention consisted of a 6-session course with five, 2-hour classes and one 3-hour silent retreat. Each session included meditations of up to 20 minutes and provided two recorded videos of 3-minute and 7-minute breath meditations for at-home practice. The recorded meditations were made shorter and simpler based on feedback from participants whom stated that the challenges of caring for a child with a chronic condition made it difficult to have a full daily meditation practice. Each session (except the silent retreat) consisted of both small and large group discussions that ranged from 20-40 minutes. The core activities of the intervention are described in Table 1.1.

**Table 1.1 Core activities of *Finding Strength for the Long-Haul* course**

<b>Session</b>	<b>Title</b>	<b>Core activities</b>
1	What is mindful self-compassion?	<ul style="list-style-type: none"> <li>• Welcome (10 minutes)</li> <li>• Group Introductions (25 minutes)</li> <li>• Inquiry and Brief Overview of Class (5 minutes)</li> </ul>

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		<ul style="list-style-type: none"> <li>• Agreements (10 minutes)</li> <li>• Growth and Overwhelm (5 minutes)</li> <li>• Introduction to Meditation (5 minutes)</li> <li>• Break (15 minutes)</li> <li>• Mindful Movement (5 minutes)</li> <li>• Activity: How Do I Treat a Friend? (10 minutes)</li> <li>• Inquiry: How Do I Treat a Friend (15 minutes)</li> <li>• Activity: Self-Compassion Break (10 minutes)</li> <li>• Inquiry: Self-Compassion Break (10 minutes)</li> <li>• Closing (10 minutes)</li> </ul>
2	What is mindfulness?	<ul style="list-style-type: none"> <li>• Opening (20 minutes)</li> <li>• Meditation: Gentle Breathing (20 minutes)</li> <li>• Inquiry: Gentle Breathing (15 minutes)</li> <li>• Break (15 minutes)</li> <li>• Mindful Movement (5 minutes)</li> <li>• Meditation: Compassionate Body Scan (20 minutes)</li> <li>• Inquiry: Compassionate Body Scan (10 minutes)</li> <li>• Activity: Comforting Touch (10 minutes)</li> <li>• Inquiry: Comforting Touch (10 minutes)</li> <li>• Closing (10 minutes)</li> </ul>
3	Compassion for self and others	<ul style="list-style-type: none"> <li>• Opening (20 minutes)</li> <li>• Activity: Awakening Our Hearts (20 minutes)</li> <li>• Inquiry: Awakening Our Hearts (30 minutes)</li> <li>• Break (15 minutes)</li> <li>• Mindful Movement (5 minutes)</li> <li>• Meditation: Loving-kindness for a Loved One and for Self (10 minutes)</li> <li>• Inquiry: Loving-Kindness for a Loved One and for Self (10 minutes)</li> <li>• Closing (10 minutes)</li> </ul>
4	Managing difficult emotions	<ul style="list-style-type: none"> <li>• Opening (20 minutes)</li> <li>• Meditation: Compassion for Ourselves in Hard Times (20 minutes)</li> <li>• Inquiry: Compassion for Ourselves in Hard Times and core concepts (15-20 minutes)</li> <li>• Break (10-15 minutes)</li> </ul>

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		<ul style="list-style-type: none"> <li>• Announcements about the Retreat (10 minutes)</li> <li>• Mindful Movement (5 minutes)</li> <li>• Meditation: Gentle Breathing with Giving and Receiving Compassion (15 minutes)</li> <li>• Closing (10 minutes)</li> </ul>
5	Silent retreat	<ul style="list-style-type: none"> <li>• Welcome and Overview (10 minutes)</li> <li>• Meditation: Compassionate Body Scan (25 minutes)</li> <li>• Walking Meditation (20 minutes)</li> <li>• Meditation: Gentle Breathing with Giving and Receiving Compassion – “One for me, One for you” (20 minutes)</li> <li>• Activity: Savoring Food (15 minutes)</li> <li>• Break (15 minutes)</li> <li>• Mindful Movement (10 minutes)</li> <li>• Activity: Just Like Me (25 minutes)</li> <li>• Meditation: Loving Kindness for Self, Parents in the Room, and Other Parents of Kids with Health Conditions (20 minutes)</li> <li>• Activity: Comforting Touch (10 minutes)</li> <li>• Activity: Write or Draw a Letter to Yourself (15 minutes) <b>OR</b></li> <li>• Activity: Finding Loving Kindness Phrases for Yourself (15 minutes)</li> <li>• Activity: Whispering with a Partner to Break Silence (10 minutes)</li> <li>• Closing Ritual (10 minutes)</li> </ul>
6	Gratitude and joy	<ul style="list-style-type: none"> <li>• Opening (25 minutes)</li> <li>• Activity: Gratitude (10 minutes)</li> <li>• Inquiry: Gratitude (15 minutes)</li> <li>• Break (15 minutes)</li> <li>• Mindful Movement (5 minutes)</li> <li>• Activity: Savoring a Moment of Joy (20 minutes)</li> <li>• Inquiry: Savoring a Moment of Joy (15 minutes)</li> <li>• Meditation: Loving-kindness for Self, Parents in the Room, Other Parents of Kids with Health Conditions (10 minutes)</li> <li>• Closing (20 minutes)</li> </ul>

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Participants in the MSC intervention were recruited from a primary care clinic serving a patient population primarily insured by Medicaid and two community organizations serving culturally diverse families of children with disabilities or special health care needs. Study information was also promoted on the Seattle Children's Hospital website. During the clinic recruitment, potential participants who met the eligibility criteria (verified through electronic medical records) were invited by their providers and/or research staff to participate in the study. During the community recruitment, community organization's leaders identified caregivers who might be interested in participating and referred those caregivers to the research staff. It was not feasible to track how many people were referred, ineligible, or refused because the program used community recruitment with flyers posted and had community organizations inviting people. A total of 29 participants were enrolled in the study. Five participants dropped out of the study after enrollment: one participant did not show up to any of the classes due to a major illness in the family and four participants were lost after the first class (1 dropped after class one due to a death in the family, 2 were lost to follow-up, 1 dropped because became homeless). The final sample included interviews (before participation in the MSC and after participation in the MSC) with 24 participants. The majority of participants were recruited through the community organizations (46%, n=11) and by the primary care clinic (42%, n=10), and three participants (13%, n=3) were recruited from Seattle Children's. Since the focal point of this study were communities of color, only the 19 transcripts (out of 24) that corresponded to the participants who self-identified as people of color were included in the analysis.

To be eligible, a participant had to be; 1) a parent or caregiver caring for a child with any chronic health condition or disability, defined by responding positively to  $\geq 1$  question on the screener used on the National Survey of Children with Special Health Care Needs (The Child &

Adolescent Health Measurement Initiative), 2) have a child with Medicaid insurance as a proxy for low income, and 3) report feeling comfortable participating in classes conducted in English. The study was determined to be exempt by the Seattle Children's Institutional Review Board.

### *Data Collection*

Two researchers (KA and HM) conducted in-depth, semi-structured interviews before and after the MSC intervention with the participants in English. The interview guides were revised iteratively but maintained the same core topics before and after the intervention to enable a pre- and post-intervention comparison. Post-intervention interviews were conducted within 6 months after the parents participated in the intervention. Example of relevant questions asked in the post-interviews are, *“How does what you learned in the class relate or not relate to your faith? Is there anything that conflicts with your faith? Is there anything from the class that aligns with your faith?”* and *“Do you identify with a particular culture? What culture? How does what you learned in the class relate or not relate to your culture?”* These questions were followed up with probes as needed for more detail. Based on the participants' preferences, interviews were conducted in their homes, a public location that offered privacy (i.e. a private room in a public library), or by phone.

The post-interviews ranged from 15 to 71 minutes, with an average length of 51 minutes. All interviews were audio-recorded and transcribed by a transcriptionist, and transcriptions were compared to the audio recordings for accuracy. All participants (n=20) were contacted for the post-interviews; 19 participants completed the post- interview and 1 participant declined due to discomfort with audio-recording. Participants received a \$35 debit card for each interview and class completed. The interview guide is included as **Appendix A**.

### *Data analysis*

Two researchers (AM and KH) used an inductive (Miles, M. B., & Huberman, A. M., 1994), constant comparison approach in which additional concepts were identified and themes derived from the interview data (Braun, Virginia, & Clarke, Victoria., 2006). Both researchers coded a total of nine transcripts together, while iteratively revising the coding scheme every three transcripts. Both researchers met biweekly to refine the codebook, adding, removing, and revising codes as needed to address inter-coder reconciliation and to compare new codes with existing codes. Once minimal reconciliation was noted between the coders, the remaining transcripts were divided up between the two researchers. We used consensus around themes that were identified throughout the coding and analysis process. Coding and analysis were conducted utilizing a qualitative web-based coding software, Dedoose. The final codebook is described in **Appendix B.**

## **Results:**

### *Demographics Characteristics of the Participants*

Table 2 shows the characteristics of the study population. All of participants were female (100%) and nearly half (47%) were between 35-45 years old. The majority of participants were foreign-born (74%) and of those, most (71%) have lived in the U.S. for over ten years. Participants predominantly identified as Black/African Descent (63%) and Hispanics/Latino (21%). Over half of the participants (58%) spoke English as a second language. About half (57.9%) of the participants identified with some form of Christianity, nearly a third (31.6%) identified as Muslim, and a few (10.5%) identified as non-religious.

**Table 1.2: Demographic Characteristics (n=19)**

<b>Characteristic</b>	<b>N (%)</b>
<b>Age</b> 25-35	3 (16)

35-45	9 (47)
45-55	4 (21)
>55	3 (16)
<b>Gender</b>	
Female	19 (100)
Male	0 (0)
<b>Foreign born</b>	14 (74)
<b>Length of time living in the U.S. for foreign-born participants</b>	
2-5 years	3 (21)
6-10 years	1 (7)
>10 years	10 (71)
<b>Race/ethnicity</b>	
Hispanic/Latino	4 (21)
Black/African Descent	12 (63)
Asian	1 (5)
Native Hawaiian/Pacific Islander	1 (5)
Other	1 (5)
<b>Religion</b>	
Christianity	11 (57.9)
Catholic	2 (10.5)
Protestant	2 (10.5)
Non-denominational	6 (31.6)
Jehovah's Witness	1 (5.3)
Muslim	6 (31.6)
Non-religious	2 (10.5)
<b>Speaks English as a second language</b>	11 (58)
<b>Language spoken at home</b>	
Arabic	1 (5)
English	7 (37)
French	1 (5)
Somali	3 (16)
Spanish	4 (21)
Other	3 (16)
<b>Educational attainment</b>	
Junior high school	2 (11)
High school	5 (26)
Some college	5 (26)
College	4 (22)
Graduate degree	2 (11)
Missing	1 (5)
<b>Referral of class to friends with children with special needs</b>	19 (100)
<b>Number of classes missed (out of 5)</b>	
0	2 (11)
1	8 (42)

2	3 (16)
4	1 (5)
Missing	5 (26)
<b>Attendance of silent retreat</b>	
Yes	11 (58)
No	8 (42)

### *Themes*

There were six overarching themes that were identified around cultural and religious beliefs and practices and how those beliefs and practices align, interact or impact the delivery of MSC intervention. We first report on alignment between MSC and religious beliefs or practices, followed by incorporation of MSC aspects into prayer practice, strengthened or improved spiritual experiences, misalignment between MSC and religious beliefs or practices, cultural barriers, and shifts in religious and cultural perspectives. Quotes are presented to illustrate the themes.

#### *Theme 1: Alignment between MSC and religious beliefs or practices.*

The majority of participants described how certain aspects of the MSC intervention mirrored or aligned with their religious beliefs or practices. Many mentioned how certain MSC practices or activities are similar, yet distinct, to what they have practiced in their church, such as being mindful, gentle, and practicing meditation. One Muslim participant put it this way, ***“You know, our faith always says you've got to be mindful, be gentle, be kind to others...”***. While another participant described the distinct similarities as such, ***“The connection was meditation. My meditation before was trying to connect with a higher being, which I still do... so this kind of meditation was trying to connect with myself with the whole body.”***

Some participants described sitting in silence in quiet spaces and practicing reflection while being with yourself as similarities experienced both during prayer and meditation, ***“The***

*prayers – I mean, the meditation, it's kind of like the prayer because you sit down, you be quiet, thinking a lot, like 10 or whatever, 15 minutes or to talk to yourself and be quiet and breathing.”* And lastly, participants mentioned how both prayer and meditation can promote feelings of relaxation and peace. One participant described the similarity as follows, *“... It's just two different ways of gaining peace and relaxation, two different ways of going about it”*.

### *Theme 2: Incorporation of MSC aspects into Prayer Practice*

Participants described the utilization and incorporation of certain MSC techniques, such as meditation, breathing, and stretching exercises into their prayer practice as a way to regulate their emotions and clear their mind before or after prayer. One participant described how she incorporated meditation into her prayer practice, *“Because before, I was looking that such a situation, and then, going to the prayer right away was like you were praying, but you feel sad. You feel like something's holding you back. But now, I do my meditation, I clear my mind, I feel comfortable, and then, I pray.”* Another participant described incorporating the practice of closing her eyes during prayer, *“So in the class you guys asked us to close our eyes and just kind of block everything out. That has helped me even in my prayer life to kind of close my eyes” [meaning that she blocks everything out]*.

### *Theme 3: Strengthened or Improved Spiritual Experiences*

Some participants noted that incorporating MSC techniques such as, meditation, breathing exercises, closing of their eyes, and stretching into their religious practices strengthened or improved their spiritual experiences post intervention. They stated that incorporating techniques improved their ability to calm down and clear their mind before or after prayer to see the bigger picture, helped them focus more during prayer and gave more depth to

their prayer experience. One participant described how closing her eyes during prayer positively impacted her overall spiritual experience, *“But I noticed when I – since I’ve been taking that class if I close my eyes, it’s like deepness... I feel and even when I open up my eyes I just feel so much relief... Like I’ve really, really truly surrendered and listened to God and he’s – I don’t know just give me a calmness within”*.

One Muslim participant described how the MSC concept of prioritizing herself empowered her to not compromise on when or where she prays, *“So, I will say that what the class did for me was just allow me to focus more on me. Not as a mother... Not as somebody who's coming to a medical clinic. Just me. Just me. Then that just makes me more firmly grounded on what my faith is... That means that I don't compromise where I'm going to pray... It doesn't matter – if I'm in transit or if I have to meet somebody... I'm going to say, ‘I can't meet you because that's the time when I'm praying.’ Then everybody else can work around that. Because when I come to you, I'll come to you with my best”*.

*Theme 4: Misalignment between MSC and religious beliefs or practices.*

A few participants mentioned experiencing activities in class that they felt opposed or interfered with their religious beliefs or practices. When asked about potential reasons why some people may not want to participate in the MSC course, one participant listed an aspect of the course that may be perceived to have a religious connotation, *“When we talk about yoga, yoga was normally practiced by the Indians in Kenya. And maybe that is one of the reasons because I had Indian friends who kept telling me “Come and learn yoga:” And I was like, ‘And pray to Hindu?’”*. One Muslim participant stated that the use of a rock during a meditation practice conflicted with her religious beliefs, *“It was just the idea that our faith doesn't put anything between us and the creator, nothing. There's no intercession... Well, the power goes to the*

*creator, not goes to a rock. Then, a lady said, 'Oh, well I never thought of it like that.' Because they started saying, 'Oh, well I carry a rock in my pocket and whenever I want, I can turn to this rock and I'll feel like this.' That's putting something in place of the creator... So, I felt it was sacrilegious".* One Muslim participant explained how the timing of the MSC intervention (offered during Ramadan) negatively affected her ability to fully engage in the activities, ***"For me, my experience, first of all, it was Ramadan. I was fasting. Most of the time when they asked me, "How do you feel?" I said I was sleepy the whole time, because I was tired"***.

#### *Theme 5: Cultural Barriers*

Participants from multiple cultures expressed how extensive or prolonged periods of meditation could be challenging for some cultures whom have never practiced. One Somali participant described how too much meditation could be challenging for fellow Somalians, ***"I mean, the – most of the class was meditation. I mean, as a Somali parent we don't know meditation. It's not our background. Meditation is something we learned from here... I think it will be great if the meditation would be less, but more like parents talk about each other and share information. And, you know, Somali people like to talk. We don't like quiet and sit... For example, there is some portion of the meditation you have to stand up and do some exercise. Those kind of things are good. It helps your body to get up, do this kind of activity"***.

Multiple participants mentioned how certain cultural beliefs or stigmas, such as the stigma of having a child with a disability or sharing personal information could prevent others of the same culture from participating in the course. One participant from Congo described how the cultural stigma of having a child with a disability could avert fellow Congolese from participating in the course, ***"One reason they, people won't speak up about it is ability. They're afraid that somebody might laugh at them. That [will] be a barrier. Even in our community,***

*you can see – ‘You have a problem with your kid?’... It's like you feel so guilty that if somebody ask you about your kid, it's like, somebody's coming to condemn you and maybe they hide them. To find somebody to speak up about the kid disability – "Yes, my kid needs help" – [is]..., hard to find".* A Somali participant shared a similar sentiment, *"There [are] a lot of parents who have kids [with]disability, but they hide... They feel ashamed. I don't know why. I mean, you didn't do anything bad, and this child didn't do anything bad, but it's just... it's just like something from God. So, I don't know why a lot of parents, they hide their kid at home, scared to show – the neighbors to know, to take outside".* A participant from Gambia explained how sharing personal information could divert fellow Gambians from participating in the course, *"...But I know a lot of Gambians but I don't know their situation. I don't tell my problem and I expect for them too they don't tell me what's exactly wrong... We don't communicate when it comes to life".*

#### *Theme 6: Shifts in Religious and Cultural Perspectives*

A few participants acquired new religious and cultural perspectives while participating in the MSC intervention. One participant stated that the MSC intervention shifted the way in which she viewed her relationship with God, *"Like before that I just sometimes I feel angry because like I said, "What"—like sometimes when I feel so angry I said why did God like—this is like test to me or exam or what? But now I feel like maybe that God loves me, like when he did this maybe he loved me to make me all the time just praying and speak with him".*

A Gambian participant shared how the cultural stigma of sharing personal information was positively impacted by the MSC intervention, *"...But when I was going to class it gave me more power for me to talk about it. Because we all need help...".* A Congolese participant describes the cultural stigma of having a child with a disability, *"If you have a kid who's sick,*

*that's your kid. You mom – take care of – make sure that you take care of him, find help for him. But if you have a healthy kid, it's the dad's kid... Hm-hmm. It's your fault that you bear a kid like that*". She goes on to describe how her view shifted after taking the MSC course, *"...But somebody brought a concept that you can leave. You are not responsible. Think good thing and bad thing can happen to everybody..."*.

**Discussion:**

This study examined how cultural and religious beliefs and practices align, interact, or impact the delivery of MSC interventions among culturally diverse communities of color caring for children with special health care needs. Overall, participants described alignment between MSC aspects and prayer practice and mentioned incorporating some MSC aspects into their religious practices. While MSC was designed to be secular, there were some MSC aspects and programmatic logistics that conflicted with religious and cultural beliefs and practices. MSC also had positive shifts in religious and cultural perspectives among some participants.

Our findings show that participants found many similarities between mediation and prayer, as both were recognized as strategies that promote mental clarity, tranquility, and peace, which supports evidence from a previous mindfulness study among a predominantly African American community (Woods-Giscombé et al., 2014). Specifically, participants across multiple cultures and religions mentioned incorporating specific MSC aspects, such as meditation, breathing exercises, closing their eyes, and stretching into their prayer practice as a way to clear their mind before or after prayer. We also found that incorporation of MSC techniques into religious practices coincided with improvements in overall spiritual experience, such as the improved ability to foster tranquility before or after prayer, enhanced ability to focus during prayer, and gave more depth to their prayer experience. The enhancement of spiritual

experiences was also noted in the study by Woods-Giscombé *et al.* (2014). This demonstrates alignment between meditation and prayer and reveals the ability of meditation practice to enhance overall spiritual experiences as an additional benefit among religiously diverse participants.

While MSC is a non-religious practice, a few conflicts with religious practices did arise among our participants. Participants mentioned how offering the MSC course during Ramadan affected their ability to fully engage in class due to prolonged periods of fasting. However, the specific participant who mentioned this attended all six sessions, which implies that the benefits of the course may outweigh the challenges of attending. Also mentioned was how the use of the word “yoga” throughout the course could be interpreted by some individuals as having a religious connotation. “Yoga” is a prominent practice in the Hindu religion; thus, this association could be a significant barrier for individuals who do not identify as Hindu. A similar finding was also reported in a study examining the cultural relevance of a mindfulness-based intervention among a predominantly African American community (majority of whom identified as Christian), in which a participant questioned whether the course was appropriate for her because the instructor accidentally mentioned Buddha (Woods-Giscombé *et al.*, 2014). In addition, the utilization of rocks as a coping mechanism tool among fellow Muslim participants was construed as a replacement for religious coping strategies, such as prayer, during stressful moments and was perceived as a religious conflict. These findings are further corroborated by an article which presents the theory that because MBIs can be a form of culture mixing, their association with religious values and beliefs may cause those with strong religious commitments to see them as infringing upon sacred elements of their culture (Palitsky *et al.*, 2019). These findings reveal how even mindfulness interventions tailored as non-religious can still be undermined by perceived

religious connotations, which can disproportionately hinder the experiences and benefits of mindfulness among communities of color. To maximize receptivity and minimize potential religious conflicts, it is vital to reiterate that MSC is a non-religious practice and preface activities by stating that concepts presented in class are intended to complement pre-existing religious or cultural coping strategies. In addition, offering a MSC course during Ramadan could reduce participation among the Muslim community and impact their ability to fully engage in activities. Future MSC courses should give particular attention to logistical details when working with predominately Muslim communities to foster equitable learning and engagement.

A few participants mentioned that the length of the meditations could be a potential cultural barrier, specifically among Somali and Latino communities in which meditation is a new concept. Mindfulness interventions among these communities should incorporate cultural adaptations to maintain meditations brief and integrate more movement. Another important finding was the pervasiveness of cultural stigma in relation to having a child with a developmental disorder or disability across multiple cultures and sharing of personal information. Participants shared that a potential barrier for uptake of MSC programs among parents of children with special health care needs in their community was the prevalence of stigma around having a child with a disability. Studies assessing family stigma demonstrated unfailingly that families of persons with developmental disabilities reported feelings of shame, embarrassment, and distress, and reported feeling marginalized by their community and family (Kabiyea, Fars, and Iris Manor-Binyamini, 2019; Song, Jieun, et al., 2018; Werner, S., and C. Shulman., 2015). These studies found stigma to be associated with negative outcomes, such as parental stress, burden, and decreased quality of life (Song, Jieun, et al., 2018; Werner, S., and C. Shulman., 2015). Future practitioners should be aware that cultural stigmas can be a moderating

factor in the acceptability of MSC programs among parents of children with special health care needs and should take appropriate steps to mitigate potential impacts on uptake.

In spite of the overwhelming prevalence of cultural stigmas, the most interesting, yet unanticipated contribution to the literature were the positive shifts in religious and cultural perspectives. Participants mentioned the realization that having a child with a disability was not the mother's fault, empowerment to openly talk about personal issues, and acquiring new perspectives on their relationships with God. During each session (except the silent retreat) parents were engaged in small and large group discussions on different topics, such as being compassionate to oneself during difficult moments and gratitude. The group setting provided a safe place for participants to interface and relate with parents experiencing similar life challenges, empowering them to talk about their personal issues. Additionally, the self-compassion component of the MSC intervention distinguishes that suffering is part of the shared human experience (Neff, 2015). The awareness and reiteration that suffering is universal, in combination with group discussions, seem to serve as the mechanism in which participants could see their situations as part of the larger human experience, unrelated to religion or culture, which could result in a shift in perspective. Both components simultaneously created an environment in which participants acquired new outlooks on having a child with a disability and their relationships with a higher power. Mindfulness practitioners should consider implementing a self-compassion component into their programs when working with communities that experience stigma due to having a child with a disability. Incorporating a self-compassion element could aid in creating a destigmatizing environment in which participants can more freely engage in dialogue.

### **Strengths and Limitations:**

This is one of the first studies that have used qualitative research methods to understand the role of religious and cultural beliefs and practices on MSC interventions among communities of color. Findings from this study can provide insight for future studies working with both diverse populations or individuals of the same cultural or religious background. However, this study has several limitations. First, parents self-selected to the study and parents who enrolled may have had different characteristics from those who didn't. In addition, findings can only be generalized to participants of similar races, ethnicities, religious affiliations, or demographic characteristics. All of the participants were female, which limited our ability to generalize the findings to men.

**Conclusion:**

This current study enriches our understanding on the interaction between religious and cultural beliefs or practices and MSC among communities of color. Our findings show alignment of MSC concepts among multiple religions, provides insight on positive impacts and additional benefits, and highlights potential barriers that can be minimized through tailored adaptations to optimize receptivity. Understanding the weight of religious and cultural beliefs on perception and receptivity can help improve the efficacy of the intervention for communities in which the presence of religion and culture are prominent. Future research might assess the degree these findings might apply in larger studies to advance and promote universal mindfulness interventions among communities of color to maximize wellbeing.

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## Appendices

### Appendix A.

#### Appendix A. Post-Interview Question Guide

##### QUESTIONS ABOUT THINGS THAT BRING HAPPINESS OR THANKFULNESS

1. I'd like to ask you to think about times that you were with your child who has a health condition or disability this past week. Could you share an example of a time where you felt joy or felt thankful, or had any kind of positive feeling? What happened?
2. What was going through your head or what did you say to yourself in that moment?
3. How often would you say you have moments like that with your child where you felt joy or felt thankful? (e.g., once a day, once a week, not often at all)

##### QUESTIONS ABOUT FACING THINGS THAT ARE HARD

1. I'd like to ask you to think about times that you were with your child who has a health condition or disability this past week. Could you share an example of a time that was hard, like when you were upset or feeling a strong emotion? What happened?
2. What was going through your head or what did you say to yourself in that moment?
3. Do you remember what you were feeling in your body?
4. How hard was it for you to calm down or feel better? Was there anything you did that helped you feel better? Was there anything from the class that you thought about or used?
5. In the past week how often have you had hard moments like this? In general how hard is it for you to calm down or feel better?

##### QUESTION ABOUT STRENGTHS

6. If you think about the past week, can you think of a time when something hard happened with one of your children and you felt good about the way you handled it? What happened or what did you do?
7. What do you remember thinking or feeling?
8. Was there anything from the class that you thought about or used?

9. How often would you say you feel good about how you handle things with your child or children?

*PROBE - If they CAN'T think of an example: Could you share what's going through your head right now, just whatever comes to mind?*

*Talked about feeling like you could always do better, not feeling like you are doing a good job – do you still find yourself feeling that way? Could you share a recent example of feeling that way? What was going through your head?*

## **QUESTIONS ABOUT WORRIES**

10. When I interviewed before, you talked about some worries or things that were on your mind [mention the things they said]. How hard is it for you to calm down or feel better when you're worrying about these things? Is there anything you do that helps you feel better when you are worried?

*Talked about being turned down when trying to access things, talked about housing, talked about your daughter's health, your health*

11. When we interviewed you before the class, you mentioned that you do or think about [\_\_\_\_\_] when you're facing a challenge.

*Talked about how your faith helps you...*

**How does what you learned in the class relate or not relate to your faith? Is there anything that conflicts with your faith? Is there anything from the class that aligns with your faith?**

*If they mention "prayer," ask about if there is any connection between the experience of meditating in the class and their experience of prayer? (e.g., some people have said they take a few breaths like meditation before they pray)*

**Do you identify with a particular culture? What culture? How does what you learned in the class relate or not relate to your culture?**

*If they mention "meditation," ask about what they do when they meditate – e.g., this about breathing, listening to a recorded meditation, repeating any of the phrases from class etc.*

12. Is there anything different now about what you do when you're worried? Could you share an example?

## **EVALUATION QUESTIONS**

13. Are there any other situations where you tried out something from the class that you would like to share – either something that worked or didn't work?

*PROBE: How helpful was it in that situation?*

*PROBE: Were there any situations where you remembered something from the class? What was the situation and what did you think about?*

*PROBE – if they didn't mention this above: Could you share any examples of using something from the class when you were with your kids?*

*PROBE: What didn't you try out and why?*

14. What was your favorite part of the class? Why?

15. What was your least favorite part of the class? Why?

17. Could you share any examples of using something from the class when you were with another person in your life, like a friend or family member, or someone who works with your child?

## **QUESTIONS ABOUT DESIGN OF FUTURE PROGRAMS**

16. What do you think about the fact that this class focused more on activities for you as a person rather than on parenting skills?

17. Are there any activities that you would recommend that we leave out in the future? Or activities that you think we should change?

***PROBE: Were there any activities that were emotionally hard for you that you think should be left out or changed?***

18. As we think about planning future courses, do you feel that the ideas or activities would be of interest to other parents or caregivers from your community, culture, or religious background, or who speak the same language you do? Why or why not? <Confirm the culture or religion that they identify with>

*PROBE: What ideas or activities do you think parents or caregivers from your community, culture, or religious background, or who speak the same language you do, might dislike or have trouble with?*

19. What do you think would be reasons why people might not want to participate in a class like this?

*PROBE: What barriers or challenges might keep them from participating?*

20. What did you think about having parents from a variety of cultural and religious backgrounds participate in this class?

*PROBE: What was good about the participants being from different backgrounds?*

*PROBE: What was challenging about it?*

*PROBE: If you were going to organize a class like this what do you think you would do when deciding who the class should be for?*

21. Often this kind of class is offered for parents or caregivers of kids with one kind of health condition, like cancer or autism. What did you think about having parents whose children had a variety of health conditions?

*PROBE: What was good about the participants having kids with different kinds of health conditions?*

*PROBE: What was challenging about it?*

*PROBE: If you were going to organize a class like this what do you think you would do when deciding who to include?*

## **WRAP-UP**

22. What do you do well as a parent?
23. What have your experiences in the class taught you about yourself?
24. Would you like to share any other suggestions or comments?
25. How was talking with me today and answering these questions?

## Appendix B. Codebook & Descriptions

<b>Code Label: Religion</b>	<b>Description</b>
1a. Alignment with Religion	Participant states that the MSC intervention aligns with their religious/spiritual beliefs or practices- or they see similarities to their religious beliefs or practices
1b. Deepened/Strengthened Religious Practice	Participant describes how the MSC intervention helped deepen, strengthened, or improved their prayer or other religious practice
1c. Empowered Prayer Practice	Participant mentioning that after taking this class they felt empowered to pray whenever they needed it for their own wellbeing
1d. Incorporating Meditation into Religious Practices	Participant states that they incorporated meditation aspects into their prayer practice
1e. Misalignment with Religion	Participant stating that the MSC intervention, or parts of it, do not align with their religious/spiritual beliefs or practices- or contradict their religious beliefs, values, or practices
1f. No Connection to Religion	Participant stating there is no connection between their religious practices and MSC practices- both activities are separate
1g. Religious Barriers	Religious/spiritual beliefs or practices that limit a participant's ability to engage in a particular activity
1h. Shift in Religious Perspective	Seeing a certain religious aspect from a different lens post intervention (i.e. thinking God is testing you but now you see it as He loves you and is using your situation to strengthen your relationship with Him)

<b>Code Label: Culture</b>	<b>Description</b>
2a. Aligns with Culture	Participant stating that MSC concepts align with their cultural beliefs, values, or practices
2b. Cultural barriers	Cultural beliefs or practices that limit a participant's ability to engage in a particular activity (i.e. not feeling comfortable to share

	experiences in class due to cultural stigma regarding disabilities)
2c. Community	Participant states that being a part of the class gave them a sense of community similar to their cultural practices
2d. Shift in Cultural Perspectives	A shift in cultural perspectives (i.e. cultural belief that having a sick or disabled child is the mother's fault but being in the MSC class made her realize it's not her fault post intervention)