Mantram Repetition With Homeless Women

A Pilot Study

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Women and families are the fastest growing segment of the homeless population. Negative attitudes of nurses toward homeless women are a major barrier to homeless women seeking health care. This cross-sectional, mixed-methods pilot study, conducted primarily by nurses, tested the Mantram Repetition Program for the first time with 29 homeless women. The Mantram Repetition Program is a spiritually based skills training that teaches mantram (sacred word) repetition as a cost-effective, personalized, portable, and focused strategy for reducing stress and improving well-being. For the cross-sectional, pretest-posttest design portion of the study, the hypothesis that at least half of the homeless women would repeat their mantram at least once a day was supported with 88% of the women repeating their mantram 1 week later. The qualitative portion of this study using phenomenology explored the women's thoughts on mantram week 2. Themes of mantram repetition, mantram benefits, and being cared for emerged. This groundbreaking, interventional, mixed-methods pilot study fills a gap in interventional homeless research. **KEY WORDS:** *homeless women*, *intervention*, *mantram repetition*, *mindfulness*

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Women and families are the fastest growing segment of the homeless population.[1] The United States has the highest number of homeless women since the Great Depression.[1] Until recently, the total number of homeless females was not collected by One Count, an annual assessment of homelessness in the United States. It is estimated that more than one-third (38%) of the homeless population is female.[1] Based on a count of 610 042 people homeless in the United States,[2] we estimate there were around 231 816 homeless females in 2013.

Homelessness, one of our most persistent and complex social problems,[3] has few documented effective answers. Published interventional studies with homeless women are rare.[4] There is increased recognition by the health care community that vulnerable populations, especially the homeless populations, require more health care services than nonvulnerable populations.[5] Homeless women have numerous unaddressed physical and psychosocial health problems that include low immunity, depression, trauma, and high mortality.[6,7] Chronic illnesses include asthma, anemia, chronic bronchitis,

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hypertension, diabetes, and ulcers.[7,8] Substance abuse is common.[8] Unmet health needs specific to women include unintended pregnancies, poor birth outcomes, and lack of preventive care such as mammograms.[8]

In the past 5 years, most of the available published data on homeless women focused on women Veterans and were obtained in support of the Veterans Health Administration's goal of reducing homelessness in Veterans.[9] The most frequent topics of homelessness found in research publications are identifying risk factors for homelessness and housing issues.[4,10-13] A 2013 systematic review of homeless Veteran women literature conducted by Byrne et al[4] identified 26 studies, and of these, only 5 tested interventions. None of these 5 studies were authored by nurses. Residential or housing interventions were tested in 4 of the 5 interventional studies.[14-17] Only 1 of the 5 studies tested a nonhousing intervention, Safety First.[18] Safety First was a labor-intensive, cognitive-behavioral program administered to 91 homeless women Veterans with a diagnosis of psychiatric or substance abuse problems.[18]

Negative attitudes of nurses toward homeless women is a major barrier to homeless women seeking health care.[19] A different non-Veteran 2013 systematic review of interventional homeless research conducted by Speirs et al[7] revealed 6 studies, all conducted before 2005.[3,20-24] Interventions were structured education, cognitive-behavioral therapy, motivational interviewing, support sessions, therapeutic communities, and advocacy.[7] Two of the 6 interventional studies were authored by nurses.[20,22] The Constantino et al[20] social support intervention showed significantly improved health outcomes. In contrast, there were no significant differences among the Nyamathi et al[22] 3 interventions of peer-mentored, nurse case-managed, or standard care on HIV risk reduction; they all improved equally.

In the last 10 years, there were no published interventional research studies with homeless women who were not Veterans. We found 1 dissertation that reported success in decreasing homelessness through strong social connections and presentation of positive life skills using an intervention called Assertive Community Treatment.[25] Most studies reported in the literature with non-Veteran homeless women used qualitative, rather than quantitative, research methods.[26-30] "Being cared for" emerged as an important theme in a qualitative phenomenological study with 15 homeless women recruited from a drop-in day shelter and an emergency winter shelter.[31] In many states, homeless women obtain help through state agencies and private foundations.[32-34]

Three published qualitative studies with homeless women have documented the importance of spirituality.[35-37] This has relevance for this study's spiritual intervention for 3 reasons: (1) Washington and colleagues[35] proposed faith and spirituality, as well as advocacy strategies, as resources for the homeless, based on their interviews with 84 older homeless African American women. (2) In a convenience sample of 90 sheltered homeless women, spiritual well-being and overall health-promoting lifestyle were moderately correlated ($r = 0.426$).[36] (3) In 222 homeless mothers with children, forgiveness, negative religious coping, and spiritual meaning predicted mental health outcomes.[37]

The Mantram Repetition Program (MRP) is a spiritually based skills training that teaches mantram (sacred word) repetition as a cost-effective, personalized, portable, and focused strategy for reducing stress and improving well-being.[38] Participants pick their own spiritual word or phrase, usually from a list of suggestions that represents all traditional religious and wisdom traditions. The MRP was adapted from Easwaran's[39] Eight Point Program and consists of 3 points: (1) mantram repetition; (2) slowing down one's thoughts, and setting priorities; and (3) focusing one's attention.[40]

This study, designed and implemented primarily by nurses, is the first time the MRP has been tested with homeless women. In earlier studies, the MRP significantly decreased symptoms of posttraumatic stress disorder,[38,41-45] depression, stress,[46,47] trait anger, and state anxiety.[40,48-50] It also increased mental health, spiritual well-being, and mindfulness.[42,45,46,48-52] The MRP has been shown to be effective with Veterans,[43-45] adults with HIV infection,[49,51,53] caregivers of loved ones with dementia,[47] childbirth couples,[54] and health care employees.[52]

METHODS

We used a mixed-methods pilot study design to test the MRP in southern California in 2013 in a sample of homeless women. For the cross-sectional, pretest-posttest design portion of the study, we hypothesized that at least half of the homeless women would repeat their mantrams at least once a day following the initial training session. In addition, we explored the associations among engagement in

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mantram repetition and the type of community site where they slept (cars vs a safe house) and self-reported demographic variables. Finally, we explored the women's thoughts on mantram use in the qualitative portion of this study using phenomenology. Prior publications from this study have demonstrated that the MRP (1) significantly decreased insomnia[55] and (2) more than half of the homeless women (54%) had previously experienced sexual trauma.[56]

Study sites

Women from 3 different community-based locations in San Diego County, California, were invited to participate in the study during October 2013. Two of these 3 community sites were safe nighttime-only parking locations. The third was a safe home for homeless women and their children.[57] Two-thirds (67%) of all homeless persons in the United States reside in California.[2] It is estimated that in San Diego County more than a quarter of unsheltered homeless adults are women—about 1076 women in 2013 alone.[58]

Study sample

We first obtained human subjects' approval from the University of San Diego's institutional review board. All resident women (N = 30) were invited to participate. A total of 29 women from the 3 sites agreed to participate in the research and signed the informed consent. One woman from one of the parking sites declined to participate and did not provide a reason.

Procedures

At baseline, the first author provided verbal descriptions of both the informed consents and the questionnaires. Women were given adequate time to individually read and consider signing the informed consents. Data were collected using a 15- to 30-minute self-report questionnaire. Three Hispanic women needing translation had the consents and questionnaires read to them in Spanish by a Spanish-speaking student. No qualitative data were gathered at this initial preintervention session.

One week later, we collected both qualitative and quantitative data on mantram repetition practice. Each woman was interviewed individually to obtain the qualitative data; time for completion varied from 15 to 30 minutes. Then, the women answered the quantitative questions with paper and pencil. They needed between 10 and 30 minutes to complete the questionnaire. At both visits, each participant was given $15 for gasoline in recognition of her time and effort for participating. We also provided water, fruit, and snack bars for the women and their children.

MRP for homeless women

The MRP skills for homeless women were delivered in 2 sessions immediately after data were collected, 1 week apart. The skills were summarized in 20 minutes by the first author. Then, the first author and students engaged the women in 15 minutes of group exercises and discussion.

In the first week, each woman reviewed a list of suggested spiritual mantrams from which to choose her own mantram. The group exercises involved participants repeating their individual mantrams silently and then repeating them out loud. As part of the instruction, women were taught to silently repeat their mantrams daily at consistent times of the day, such as waking up, before meals, and every night before sleep. We emphasized that it might take from 6 weeks to 3 months of practice before mantram repetition significantly improved their sleep or reduced their stress. Both the first author and nursing students exhibited intentional, caring behavior with smiles, laughter, assistance with child care, and individual conversations with the women.

A pocket-sized laminated booklet with daily mantram suggestions was given to each participant. The daily suggestions covered the 3 critical practices in the MRP: (1) mantram repetition; (2) slowing down; and (3) one-pointed attention. Each woman received a half-inch blue rubber bracelet to wear on her wrist as a reminder to repeat her mantram. The band had the words: "MANTRAM—A Pause Button for the Mind!"

The second week's training reinforced the importance of regular, consistent repetition practice. The concepts of slowing down and one-pointed attention were discussed and demonstrated. Initially, the first author and students modeled slowing down while repeating one's mantram, followed by each woman's practice of slowing down while repeating her mantram. Then one-pointed attention was discussed and demonstrated, followed by each woman's practice of all 3 steps of the MRP: mantram repetition; slowing down; and one-point attention. We provided distractions of loud noises and funny faces in front of each woman's face during this exercise.

Throughout both training sessions, frequently occurring distractions were incorporated into the

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teaching and used to demonstrate the need for one-point attention. These distractions included running children, people walking through the group to access the nearby bathrooms, loud airplanes taking off and landing at an adjacent airport, and people returning from their daytime work.

Measures

We collected both quantitative and qualitative data. Demographic variables—age, marital status, education, and family income—were measured with a self-report questionnaire from previous research studies. Written at a seventh-grade reading level, these items were reliable with a Spearman-Brown prophecy score of 0.8.[59,60] Race and ethnic descriptions were based on the US Census Bureau descriptions.[61]

To measure mantram use, we asked each woman, "Are you using your mantram?" If she answered, "Yes," we asked her to tell us how many times per day (0-7) and the number of days the previous week (0-7) she had used mantram. These questions have face validity. Other validity and reliability data are not available.

The phenomenological perspectives of mantram use were explored with individual, face-to-face, in-depth, semistructured interviews with 2 questions developed by the first author: (1) "Tell me about your mantram"; and (2) "What else about mantram do you want to talk about?" Instructions after question 1 provided direction based on each woman's response: (1*a*) If the woman's answer included "not using mantram," we asked "What gets in your way?" (1*b*) If the woman was using her mantram, we asked, "What makes it possible for you to practice your mantram repetition?" The interviewers were instructed to pause after asking each question—"Give her time to talk more if she wishes." Each woman's answers were written by the interviewer on a piece of paper as the homeless woman talked. The conversations were not taped because of limited resources.

Analyses and data entry

Data were double entered into SPSS v. 21, with a data entry accuracy of 98%. Descriptive analyses were conducted to describe the sample and frequency of mantram use. Four variables with multiple-response options were recoded into 2 or 3 categories: race, ethnicity, education, and income. Other variables were binary.

Two factors made inferential statistics inappropriate for all variables except community sites: small sample size and small variability. The sample was small, with 29 women who participated the first week and 24 women the second week. Also, some women failed to answer select questions, such as income, in the first week (Table). This would have meant impractically small statistical power $(1 - \beta)$[62] and therefore reported percentages and estimated effect sizes, as is appropriate for studies with small samples.

For all of the demographic variables except community sites, there was very little variability in mantram use. Only 3 women did not use their mantram, whereas 21 women were still using their mantrams 1 week later. The one exception to insufficient variability was community sites (cars vs a safe house). Among the 24 women who returned 1 week later, all 17 homeless women who slept in their cars (100%) reported mantram use. In contrast, among the 7 women who slept at the safe house, 57% ($n = 4$) reported mantram use. This variability from 57% to 100% in community sites makes inferential statistics possible. Thus, we provide χ^2 test results for the association between mantram use and type of community site.

Thematic analyses of the in-depth qualitative written interviews were completed by the first author on 2 separate occasions, 1 month apart. The first analyses identified main themes from the written interviews. The second analyses clarified the main themes and selected representative verbatim comments for each theme that emerged. These themes were confirmed by consensus with a coauthor.

RESULTS

Twenty-nine of 30 available women participated in the study at baseline. There was no explanation provided by the 1 woman who declined to participate and who stayed isolated within her car with her windows rolled up. One week later, 24 (83%) women returned and answered questions about their mantram use. Only 5 (17%) of the original 29 women did not return. Explanations provided for 4 of the 5 absent women were sickness ($n = 1$), work ($n = 1$), moved in with father ($n = 1$), or moved in with sister ($n = 1$). We were unable to obtain information on why the fifth woman did not return.

The mean age of group was 45 years ($SD = 12.2$). Fifty-two percent of participants were white; 48%

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TABLE. Demographics, Social Characteristics, and Effect Size for Mantram Repetition in Homeless Women[a]

	n	%	Medium Effect Size[b]
Mantram repetition[c] (n = 24)			
Yes	21	88	
No	03	12	
Demographics			
Age, y (n = 29)			$\eta^2 = 0.314$
$\bar{x}$	45 (12.2)		
Range	26-65		
Race (n = 25)			
White (excluding Mexican)	12	48	
Mexican	05	20	
AA and Other	08	32	
Ethnic origin (n = 27)			
Hispanic	12	44	
Non-Hispanic	15	56	
Marital status (n = 26)			
Single, separated, or divorced	20	77	
Married or widowed	06	23	
Education (n = 29)			
High school or less	14	48	
Greater than high school	15	52	
Family income (n = 20)			$\varphi = -0.336$
<$12 000	14	70	
$≥12 000	06	30	
Social			
Children (n = 23)			$\varphi = 0.405$
Yes	11	48	
No	12	52	
Usual place to sleep (n = 24)			$\varphi = 0.589$ $p = .004$
Cars	17	71	
Amikas Home	07	29	

[a] φ = coefficient is used to capture the relationship for 2 binary (nominal) variables; small/medium/large = 0.01/0.03/0.05; η^2 = a variance explained effect size; small/medium/large = 0.01/0.059/0.138.
[b] Medium effect sizes listed. Small effect sizes are not listed.
[c] Sample size for individual variables varied from 20 to 29: n = 29, initial questionnaire, unless women failed to answer specific questions; n = 24, 1 week later, unless women failed to answer specific questions.

were Hispanic or Latino. Most of the women were single, separated, or divorced (77%) and had education beyond high school (52%). Family income for the majority of the women (70%) bordered at or around poverty levels, defined as less than $12 000 per year. The 2013 poverty guidelines for a family of 1 in 2013 was $11 490 per year; for a family of 2, it was $15 510.[63] Additional descriptions on demographic differences between the 2 sites have previously been reported.[56]

Answer to research hypothesis and exploratory research

The research hypothesis related to repeating one's mantram was confirmed, with 88% (n = 21) of the homeless women repeating their mantram at follow-up once a day or more. Both times per day and days per week were used to measure the number of mantram repetitions. For times per day, the 21 women reported a range of 1 to 12 times per day, with a mean of 4.1 (SD = 0.7) times per day. For times per week, the range was 1 to 7 days, with a mean of 4.4 (SD = 0.5) days per week.

Exploratory research revealed medium effect sizes between mantram repetition and 3 other variables: (1) age; (2) income; and (3) type of community site. With age, a medium effect size ($\eta^2 = 0.31$) revealed that older women were more likely than younger women to repeat their mantram. There were income data for 20 of the 24 women who returned 1 week later. A medium effect size ($\phi = 0.34$) revealed that having

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lower income was associated with a greater frequency of mantram repetition. Among the 14 women who had less than $12 000 in income, 93% (n = 13) repeated their mantrams; whereas among the 6 women who had incomes of $12 000 or greater, 67% (n = 4) repeated their mantrams. The other 4 demographic variables—race, ethnicity, marital status, and education—showed only weak effect sizes.

There were 2 types of community site: car parking lots (2) and a safe house. All of the 17 homeless women who slept in their cars (100%) reported mantram use. But of the 7 women who slept at the safe house, only 57% (n = 4) reported mantram use during the week. Chi-square analyses revealed a statistically significant relationship and medium effect size between community sites and mantram use: $\chi^2_1 = 8.3$, $P = .004$ ($\phi = 0.59$).

Qualitative results

The women readily participated, were highly interactive, and enjoyed the distraction exercises designed to strengthen one-pointed attention. In week 2, one woman actively participated in teaching the course by repeating her mantram and discussing many situations in which she had benefitted from its use. This same woman in week 1 had selected a personal mantram of "narrow escape." During the week, she had changed her mantram to "Jesus Christ." Her change in behavior from being withdrawn, disruptive, and stressed at week 1 to outgoing and highly interactive with a constant smile at week 2 was representative of the many nonverbal changes and benefits observed in numerous women by the interviewers as a result of their mantram repetition.

Three themes emerged from the qualitative interviews: (1) mantram repetition; (2) mantram benefits; and (3) being cared for. "It has to be made a habit" was an example of the mantram repetition comments. Mantram benefits were represented by this woman's comments: "I used to get real upset when my boss hollered at me. Today, I repeated my mantram over and over in my mind as he was screaming. He did not know what I was doing. I was okay." Two examples of the women's verbal expressions of being cared for were:

> You all care about us . . . . Most people see us and just see homeless. People see my front teeth knocked out and think I will hurt them. They don't know they [teeth] were knocked out when I was knocked out senseless.

> You all care for us; you do not treat us like others who just pass us on the street and pretend we do not exist.

DISCUSSION AND LIMITATIONS

There are no other mixed-methods interventional research studies in the literature with which to compare this study's results. The finding that homeless women will participate in interventional research is compatible with the 1 health interventional research study identified with a 2013 Byrne et al[4] systematic review of homeless Veteran women literature[18] and the 6 quantitative studies identified through a 2013 Speirs et al[7] systematic review of interventional homeless research.[3,7,20-24]

The MRP was a quick, easy-to-teach, and easy-to-implement intervention that was taught in 35 minutes. Mantram repetition is also quick and efficient for each woman to implement as one's mantram can be repeated mentally and quietly in a minimum of 5 seconds. In contrast, the 11 different interventional homeless research studies identified from 2 different systematic literature reviews were labor-intensive and costly (5 studies by Byrne et al[4] and 6 studies by Speirs et al[7]). Their implementation times varied from 90 minutes a week for 8 weeks for a social support intervention[20] to 3 years. The estimated hours per year were not provided for the 3-year health advocacy program.[21]

Only 2 of the 11 different interventional homeless research studies,[20,22] identified through 2 systematic reviews of homeless literature,[4,7] were authored by nurses. This groundbreaking, interventional, mixed-methods pilot study fills a gap in interventional homeless research conducted by nurses. The MRP was taught efficiently to nurses and graduate nursing students for implementation with homeless women.

Nursing education is needed to address the documented negative attitudes of nurses toward the homeless.[19] Homeless women's decreased access to health care as a result of nurses' negative attitudes is in direct conflict with nursing's caring philosophy[64] on which the nursing profession is based. Experiential programs for nurses to change negative attitudes and to increase nurses' awareness of the multiple health needs of homeless women are critically needed. The "cared for" theme reported in this study's phenomenological analyses is virtually identical to the "cared for" theme reported in the Biederman et al[31] phenomenological research. However, the source of the homeless data varies between the 2 studies. The

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Biederman et al research recruited women from a drop-in day shelter and an emergency winter shelter. This study recruited homeless women who slept in their cars or a safe house. The "cared for" theme that evolved from both studies provides strong support for active involvement of nurses in future interventional homeless women research. Nursing and caring have always been intertwined.[64] This study created and implemented by nurses is a beginning step in correcting the impact of nurses' negative attitudes that have been shown to be a barrier for homeless women in accessing health care.[64]

The spiritual component of the MRP is compatible with the 3 previous qualitative studies with homeless women that documented the importance of spirituality.[35-37] Many potential spiritual interventional homeless programs would use a one-approach spiritual doctrine for all participants. In contrast, the MRP is unique due to its individualized selection of a mantram. The MRP allows for different mantrams based on a diversity of religious backgrounds among the participants. The individualization and specificity of the MRP would not be available in a traditional spiritual program.

Results from this study can be generalized to homeless women who sleep in their cars at a safe parking lot at night or who live in a safe home in the southwestern part of the United States. Limitations include the lack of a control group and a small sample size. Another limitation is the handwritten qualitative data. This reduced the richness of the data in contrast to taped conversations, which would have been the preferred method, if additional funding for transcribing and analyses had been available. Study strengths include a quick, effective, meditative intervention for homeless women, a mixed-method (qualitative and quantitative) design, and 2 different community homeless sites. Future randomized control trials are needed with a control group, a larger number of homeless women at other homeless community sites, and a longer follow-up to assess for continued use of mantram repetition among homeless women.

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