



2014] and expression of growth factors, such as the brain-derived neurotrophic factor [Phillips C et al. *Front Cell Neurosci.* 2014].

A substantial body of evidence supports the value of exercise in the treatment of people with depression [Stanton R, Happell BM. *Issues Ment Health Nurs.* 2013]. Mr Bergmark's prescription calls for 45 minutes to 1 hour of aerobic activity (eg, walking, running, swimming, or cycling) for a minimum of 3 to 5 days a week. Intensity should be low to moderate to start, with an increase to a moderate level over time.

Collaborative arrangements with a health and fitness center willing to support prescription recommendations and provide incentives (eg, a free 1-week pass) and follow-up (eg, ongoing assessment) can help patients start exercising. Use of evidence-based counseling can promote behavior change and adherence.

Motivational interviewing, a form of collaborative conversation in which clinicians elicit and explore a patient's own reasons for change, is an empirically supported counseling style that strengthens a patient's own motivation and resolve [Zuckoff A. *Surg Obes Relat Dis.* 2012]. Rather than telling patients what to do and how to do it, clinicians invite them to share the doubts, reasons, and concerns that make them uncertain that they are ready to change. By understanding and accepting those reasons, they can then ask patients to explain why they might want to change, the potential benefits as they see them, and how adherence would be consistent with what they care about or value most.

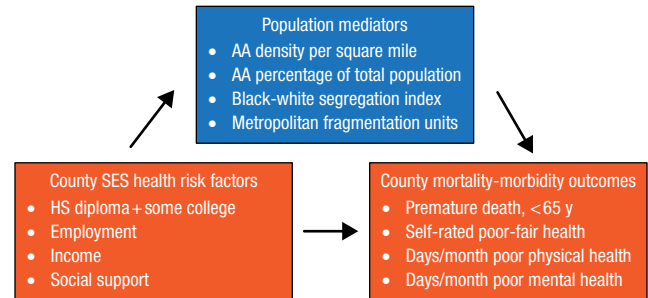
In the context of motivational interviewing, it becomes possible to elicit a commitment to change, which, in turn, predicts new behavior [Amrhein PC et al. *J Consult Clin Psychol.* 2003]. Ultimately, the decision to exercise despite depression is a byproduct of a clinician-patient partnership, a relationship based on trust. It is an alliance that encourages and supports a patient's choice to adopt a lifestyle that serves his or her own best interests.

African American Population Percentage Negatively Mediates SES Association With Poor Mental Health

Written by Toni Rizzo

Social inequities are strongly associated with health disparities. Research shows that chronic and traumatic social inequities can be epigenetic and complicate the health risks of inflammatory illnesses such as type 2

Figure 1. Social-Ecological Model of African American Population: Effects on SES and Health



AA, African American; HS, high school; SES, socioeconomic status.
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diabetes, cardiovascular disease, and depression. Linda D. Oakley, PhD, University of Wisconsin, Madison, Wisconsin, USA, presented the findings of this study, conducted with Rick P. Voland, PhD, University of Wisconsin, Madison, Wisconsin, USA which tested basic assumptions of the epigenetic biological link between social inequities and health disparities in African Americans living in the United States.

The study design was guided by an upstream social-ecological model of race as a potential mediator of the relationship between social inequities and health disparities (Figure 1).

The study sample was collected from US population data aggregated by county [University of Wisconsin Population Health Institute. 2014 County Health Rankings. 2014]. The mediators tested were African American total population, density, and percentage; level of black-white population segregation; and nonracial fragmentation of municipal infrastructures. Socioeconomic status (SES) was defined as the percentage of county adults who had a high school diploma with or without some years of college, were unemployed, lacked support, and had children living in poverty. Health outcome variables were premature mortality, fair or poor health, number of days of poor physical health, and number of days of poor mental health. Premature mortality was defined as mean years of life lost before age 65. Fair-poor health was defined as mean adult self-ratings of fair or poor health. A poor physical health day was defined as mean days lost in the past month due to poor physical health. A poor mental health day was defined as mean days lost in the past month due to poor mental health.

The total county population was 233584 (11.1%) African Americans, with a mean African American density per square mile of 4993. The mean number of premature

Table 1. Model Estimates for African American Percentage of County Population as Mediator of SES Effects on County Health Outcomes

Health Outcome	β	SE	95% CI	No.	R ²	%M
PM				2289	0.657	2.7
(a) SES → AA%	-0.48	0.03	-0.53 to -0.43			
(b) AA% → PM	0.05	0.02	0.01 to 0.08			
(c') SES → PM	-0.79	0.03	-0.85 to -0.73			
(ab) SES → AA% → PM	-0.022	0.008	-0.037 to -0.006			
Total effect	-0.81	0.03	-0.87 to -0.75			
FPH				2390	0.695	-9.0
(a) SES → AA%	-0.50	0.03	-0.55 to -0.45			
(b) AA% → FPH	-0.15	0.02	-0.18 to -0.12			
(c') SES → FPH	-0.90	0.03	-0.96 to -0.83			
(ab) SES → AA% → FPH	0.074	0.009	0.057 to 0.092			
Total effect	-0.82	0.03	-0.89 to -0.76			
PPHD				2433	0.509	-11.0
(a) SES → AA%	-0.50	0.03	-0.55 to -0.45			
(b) AA% → PPHD	-0.27	0.02	-0.30 to -0.23			
(c') SES → PPHD	-0.81	0.03	-0.87 to -0.74			
(ab) SES → AA% → PPHD	0.132	0.012	0.109 to 0.155			
Total effect	-0.68	0.03	-0.74 to -0.62			
PMHD				2433	0.353	16.7
(a) SES → AA%	-0.50	0.03	-0.55 to -0.45			
(b) AA% → PMHD	-0.19	0.02	-0.23 to -0.15			
(c') SES → PMHD	-0.67	0.03	-0.73 to -0.61			
(ab) SES → AA% → PMHD	0.095	0.012	0.073 to 0.118			
Total effect	-0.57	0.03	-0.62 to -0.52			

Significance, $\beta \geq 0.1$, 95% CI.

AA%, African American percentage of total county population; (ab), indirect SES effect on county health outcome; (c'), direct SES effect on county health outcome; FPH, fair-poor health; %M, percentage of total effect on county health outcome explained by inclusion of AA% in the model; PM, premature mortality; PMHD, poor mental health days; PPHD, poor physical health days; SES, socioeconomic status.

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deaths in years per 100 000 was 7273. The percentages of African Americans with fair or poor health, poor physical health days per month, and poor mental health days per month were 15.2%, 3.6%, and 3.4%, respectively. The high school graduation rate was 81.7%, and 60.2% attended some college. Almost 20% of African American children were living in poverty. The percentages of African Americans with no socioeconomic support or employment were 19.3% and 9.2%, respectively.

The African American percentage of the total county population was the only mediator associated with both SES and health outcome variables (Table 1). The impact indices for all but 1 health outcome were significantly ($\beta \geq 0.1$, 95% CI) associated with the African American population percentage.

The African American total number, the African American county density, the black-white segregation level, and municipal fragmentation were not associated with either SES or county health outcomes.

Poor mental health days had the largest (16.7%) mediating effect with respect to race. The association of SES with poor mental health days was negatively mediated by the population percentage of African Americans. This mediation effect decreased as the population percentage of African Americans increased. Psychiatric nursing assessment of poor mental health in persons coping with comorbid illnesses and problems with education, employment, social support, and poverty should include the social-ecological effects of race.

Christians Seeking Psychiatric Care May Appreciate Special Care

Written by Toni Rizzo

Moderately and very religious Christians often seek psychiatric care from Christian providers. In the United States, 78.4% of the population identify as Christians [US Religious Landscape Survey. Pew Forum on Religion & Public Life. 2008], but there have been no published studies on the reasons Christians seek Christian mental health providers. Additionally, no published studies have addressed cultural competence for Christians receiving psychiatric care. The purpose of this literature review, presented by Melissa Ott, DNP, PMHNP-BC, Vanderbilt University School of Nursing, Nashville, Tennessee, USA, was to determine how the Christian populace would like to receive psychiatric treatment in order to enhance the psychiatric care of these patients.

A literature review of published studies from 2000 to 2013 was conducted using PubMed as the primary search engine. The key search words were faith, Christian, mental

health care, depression, anxiety, and psychiatric illness. Included were Christian adults with psychiatric mood disorders that affected their quality of life, life satisfaction, and perception of God. A total of 48 qualitative and quantitative articles were retrieved.

The analysis showed that Christian patient perception was influenced by the level of the provider's comfort with his or her own religiousness [Baetz M et al. *Can J Psychiatry*. 2004; Baetz M et al. *J Nerv Ment Dis*. 2002]. Men who regularly attended church had a higher likelihood of depression vs those who changed their frequency of attendance [Maselko J, Buka S. *Soc Psychiatr Epidemiol*. 2008]. Another study found that religious males were less likely to commit suicide [Olliffe JL et al. *Soc Sci Med*. 2012]. Gur and colleagues [J Nerv Ment Dis. 2005] reported that maternal Christian faith did not protect offspring from developing depression. A study of an older male adult prison population found that those with an interpersonal relationship with God had better mental health [Allen RS et al. *Gerontologist*. 2008].

Attending religious services was found to decrease depression [Reese AM et al. *J Urban Health*. 2012; Taylor RJ et al. *J Nerv Ment Dis*. 2012; Baetz M et al. *J Nerv Ment Dis*. 2004] and suicide ideation or attempts [Robinson JA et al. *Depress Anxiety*. 2012; Rasic D et al. *J Psychiatr Res*. 2011]. Prolonged trauma may lead to feelings of abandonment by God, as in the case of some people after the LAquila earthquake in Italy [Stratta P et al. *J Affect Disord*. 2012]. Monthly religious attendance was associated with increased tranquility [Ellison CG et al. *Soc Sci Res*. 2009]. Another study reported that a belief in a loving God decreased anxiety, whereas belief in a punitive God increased anxiety and guilt [Rosmarin DH et al. *Cogn Behav Ther*. 2009].

The gaps in the literature include studies on the reasons Christians often see Christian psychiatric providers. Christians receiving psychiatric care often have specific needs, including praying, sharing biblical verses, and having the desire to discuss their faith. These factors help to define cultural competence for this population. More research defining how much religious involvement Christian psychiatric patients wish to receive would be beneficial. Such studies would help both Christian and secular providers better understand how to effectively treat this population.



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