Resilience: Protective Factors for Depression and Post Traumatic Stress Disorder among African American Women?

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Abstract

There is a great need to carefully examine issues that may elevate one's risk for mental illness and develop strategies to mitigate risk and cultivate resilience. African Americans, specifically African American women (AAW), are disproportionately affected by mental illness, including depression and post-traumatic stress disorder (PTSD). Higher rates of PTSD among AAW may be explained by significant rates of trauma exposure. Higher resiliency in individuals with mental illnesses is associated with better treatment response/outcomes. An examination of two (2) promising psycho-educational curricula for AAW at risk for depression and PTSD supports consideration of resilience as a protective factor among this population. Strengthening psychological resilience among diverse AAW at risk for depression and/or PTSD may serve as a protective factor for symptom severity. Multidimensional prevention and intervention strategies should incorporate culturally-centered, gender-specific, and strengths-based (resilience) models of care to help encourage mental health help-seeking and promotion of wellness for AAW.

Keywords: *African American Women, Post-Traumatic Stress Disorder, Resilience, Depression, Psycho-education*

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I. Introduction

Mental Illness in the United States

Maintaining optimum mental health is an important aspect of a person's overall health status. Mental illness affects an individual's well-being, family and interpersonal relationships, and the ability to contribute to society, and are very common in the United States. According to the National Survey on Drug Use and Health (NSDUH), approximately 43.6 million adults aged 18 or older experiences mental illness in a given year (Center for Behavioral Health Statistics and Quality, 2015). The NSDUH defines any mental illness as: (a) a mental, behavioral, or emotional disorder (b) currently diagnosed or diagnosed within the past year and (c) meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). Mental illness can range in impact from no or mild impairment to significantly disabling impairment, such as in individuals with serious mental illness (SMI), defined as individuals with a mental disorder with serious functional impairment which substantially interferes with or limits one or more major life activities. Among adults with mental illness in the past year, almost 23% had SMI (Center for Behavioral Health Statistics and Quality, 2015). Thus, as researchers, clinicians, public health professionals, and policymakers there is an immense responsibility to carefully examine issues that may elevate an individuals' risk for mental illness and develop strategies to mitigate risk and cultivate resilience.

Prevalence of Mental Illness and African Americans

In 2014, 16.3% of adults aged 18 and older with mental illness were African American (Center for Behavioral Health Statistics and Quality, 2015); and African Americans are 20% more likely to experience serious mental health problems than the general population [U.S. Department of Health and Human Services (DHHS), 2014]. African American adults living below poverty are three times more likely to report serious psychological distress than those living above poverty (DHHS, 2014). African American adults are more likely to experience feelings of sadness, hopelessness, and worthlessness than white adults (DHHS, 2014). Recent estimates of mental health morbidity find that African Americans experience more severe forms of mental health conditions due to unmet needs and other barriers such as racism, socioeconomics, access to care etc. (DHHS, 2001; DHHS, 2014). African Americans are also more likely to experience certain factors that increase the risk for developing a mental health condition such as homelessness and exposure to violence (Fothergill, Doherty, Robertson, & Ensminger, 2012; Bennett & Joe, 2015) As the ethnic and cultural diversity of the patient population continues to expand, the importance of cultural competence among medical professionals becomes greater for treating African Americans (Holden & Xanthos, 2009). This is particularly important for African American women seeking care for depression in in primary care settings (Shim et al., 2013). Common mental health disorders among African Americans include depression and post-traumatic stress disorder (PTSD).

Depression and African American Women

Major depression is one of the most common mental disorders in the United States affecting approximately 15.7 million adults (Center for Behavioral Health Statistics and Quality, 2015). Women have higher rates of depression than men and the same applies to African American women (Center for Behavioral Health Statistics and

Quality, 2015). African American women are often identified as a group at greater risk for depression, being twice as likely as men to suffer from it (Center for Behavioral Health Statistics and Quality, 2015). Major depression accounts for the heaviest burden of disability among mental and behavioral disorders. Specifically, major depression accounts for: 3.7% of all U.S. disability-adjusted life years; and, 8.3% of all U.S. years lived with disability [World Health Organization (WHO), 2010]. Projections for the year 2030 estimate that major depression will be the leading cause of the total disability worldwide (Alonso, 2012). Depression is also associated with reduced productivity, and poorer quality of life (Lehman, 1996; Jain et al., 2013).

There is a dearth of research studies on depression among African American women [Carrington, 2006; American Psychological Association (APA), 2010; Bailey, Patel, Barker, Ali, & Jabeen, 2011). Studies that do exist find that depression in African American women is often invisible, misdiagnosed or underdiagnosed, and ineptly treated (Rickert, Wiemann, & Berenson, 2000; Bailey et al., 2011). Black women are vulnerable to depression due to chronic environmental stressors of racism, discrimination, sexism, poverty, cultural socialization practices, and social health difficulties (Schneider, Hitlan, & Radhakrishnan, 2000). Although African American women are disproportionately affected by depression, only 7.6% sought treatment for depression compared to 13.6 percent of the general population in 2011 [Substance Abuse and Mental Health Services Administration (SAMHSA), 2012]. Stigma has been identified as the most significant barrier to seeking mental health services among African Americans (DHHS, 2001; Sanders-Thompson, Noel, & Campbell, 2004). A 2010 study, found that many women in their study did not identify stigma as a barrier and although these women endorsed treatment-seeking, they also identified faith, prayer, and informal support from friends and family as important preferred coping mechanisms. Holden, Belton, & Hall (2015) reported the following perceptions of contributing factors to African American women's experience of depression: lack of control in life, difficulties with personal relationships, multiple and demanding social roles, chronic stressors, and poor personal well-being. Other studies (Waite & Killian, 2008; Holden, Belton, & Hall, 2015) concerning health beliefs about depression among African American women suggest that a culturally-centered environment that promotes empowerment as an approach for coping with depression is ideal. Ethnically and culturally diverse women in general, and African American women in particular, are poised to receive increased attention from mental and behavioral health professionals to address their issues.

Post-Traumatic Stress Disorder and African American Women

PTSD is an anxiety disorder that can develop after exposure to a terrifying event and/or ordeal in which an individual has experienced or witnessed (National Institute of Mental Health, 2015). These terrifying or traumatic events include natural and human caused disasters, accidents, violent personal assaults, and military combat. Although exposure to a traumatic experience is required for the development of PTSD, trauma alone does not insure a PTSD diagnosis. Persons with PTSD experience constant frightening thoughts and memories of that traumatic experience, may have trouble sleeping, feel anxious or numb, or can be easily startled. PTSD can last for years and severely impair day-to-day functioning. There are also substantial public health consequences associated with PTSD such as suicide (Stevens et al., 2013), secondary mental disorders, substance dependence (Breslau, Davis, & Schultz, 2003), impaired role functioning, health problems (Sledjeski, Speisman, & Dierker, 2008) and reduced life course opportunities, such as unemployment and marital instability (Kessler, 2000).

The prevalence of PTSD in the general population varies by many factors including age, gender, and type of trauma. Currently, almost eight million Americans (3.5%) are affected by PTSD, but women are more likely to develop the condition than men (Kessler, Chiu, Demler, & Walters, 2005). Lifetime prevalence rates of PTSD in the U.S. population range between 6.8 and 12.3 percent (Kessler, Berglund, Demler, Jin, & Walters, 2005). About 37% of those affected by PTSD are classified as severe (Kessler, Chiu, Demler, & Walters, 2005). While PTSD can occur at any age, the average age of onset is 23 years old (Kessler, Chiu, Demler, & Walters, 2005). Research has revealed higher rates of lifetime prevalence of PTSD among African Americans (8.7%) compared to non-Latino whites (7.4%) or Asians (4.0%) (Roberts, Gilman, Breslau, Breslau, & Koenen, 2011). Consistent with Roberts et al. (2011), another study using a different data set also found lifetime prevalence of PTSD to be higher among African Americans, while Asians and Latinos have lower prevalence rates of probable lifetime PTSD, as compared to non-Latino whites (Alegría et al., 2013).

Higher rates of PTSD among African American women may be explained by significant rates of trauma exposure, especially among those that are economically disadvantaged (Breslau et al., 1998; Alim, Charney, & Mellman, 2006; Carr et al., 2012). Studies show that African Americans have significantly higher exposure to assaultive violence than Whites (Roberts et al., 2011). Furthermore, African Americans of all ages are more likely to be victims of serious violent crime than are non-Hispanic whites, making them more likely to meet the diagnostic criteria for post-traumatic stress disorder (PTSD). Types of violence commonly impacting African American women include childhood sexual abuse, dating violence/intimate partner violence, sexual assault, and sexual harassment (West, 2014). Reduced social support also contributes to the prevalence and subsequent exacerbation of PTSD (Brewin, Andrews, & Valentine, 2000). Exhibition of PTSD symptoms in African American women often lead to involvement in risky behaviors (i.e. alcohol/substance abuse and risky sexual behaviors) that serve as a function of avoidance or escape (Sullivan & Holt, 2008; Sullivan, Cavanaugh, Buckner, & Edmondson, 2009; Weiss, Tull, Viana, Anestis, & Gratz, 2012; Weiss, Tull, Borne, & Gratz, 2013). Behavioral health professionals should prioritize identification and responding to the unique issues generated by trauma exposure among this population, and develop skills to promote trauma-focused treatment engagement and resilience skill building.

II. Theoretical Framework

The cultures of racial and ethnic minorities, including African American women, influence many aspects of mental illness, including how patients from a given culture communicate and manifest their symptoms, their style of coping and their willingness to seek treatment (DHHS, 2001). The co-authors recognizes the importance of cultural sensitivity as a central component of an effective comprehensive model of care for ethnic minorities. A key issue for clinicians and researchers will be conducting the appropriate background research on cultural tenets that may have significance for various groups (Holden et al., 2014). Furthermore, it is imperative that any culturally centered collaborative model consider the multi-faceted aspects of socio-cultural, environmental, and psychosocial issues that may be encountered by the target population of interest. This systemic approach will require focused attention, active participation, strategic collaboration, and sharing of resources among stakeholders from multiple sectors. This is particularly important for African American communities to support the reduction of stigma about mental health treatment. Thus, community education and prevention efforts about mental health issues can be enhanced through a values-based and values-driven approach to culturally centered health care for African American women.

Moreover, a social ecological conceptual framework for addressing the myriad of complex and interrelated factors that can influence help-seeking behaviors among African American women should be considered to help foster interdisciplinary approaches to discovery science that elucidate the etiology of mental health disparities and social determinants of mental health, and create innovative interventions to enhance the health and well-being of ethnic minorities. The social ecological model (SEM; McElroy, 1988) of health (see Figure 1) is a multi-level approach with multiple bands of influence. At the core of the model is the individual, surrounded by four realms of influence representing the individual, interpersonal, organizational, and community levels. These four levels of the SEM maximize synergies of intervention for the greatest impact. The SEM presumes that it is important to handle these important influences simultaneously, as well as the barriers in an individual's environment that may influence their quality of life and likelihood of engaging in health-promoting behaviors. Individual Level: the innermost band of the SEM model represents the individual whom is ultimately affected by knowledge and influenced by his/her beliefs about and attitudes toward health issues. Interpersonal Level: The second band of the SEM surrounds the individual band and represents activities implemented at the interpersonal level. These activities are intended to facilitate individual behavior change through interpersonal communication and support aimed at affecting social and cultural norms and overcoming individual-level barriers. Friends, family, health care providers, community health workers, and patient navigators represent potential sources of interpersonal messages and support. Organizational Level: The third band of the SEM surrounds the interpersonal band and represents activities implemented at the organization level. These activities are intended to facilitate individual behavior change through communication and support aimed

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at influencing organizational systems and policies. Health care systems, employers or worksites, health care plans, local health departments, and professional organizations represent potential sources of organizational messages and support. Community Level: The fourth band of the SEM surrounds the organizational band and represents activities implemented at the community level. These activities are intended to facilitate individual behavior change through communication and support by leveraging resources and participation of community-level institutions such as comprehensive primary healthcare centers, community coalitions and advocacy groups, and media which represent potential sources of community communication and support.

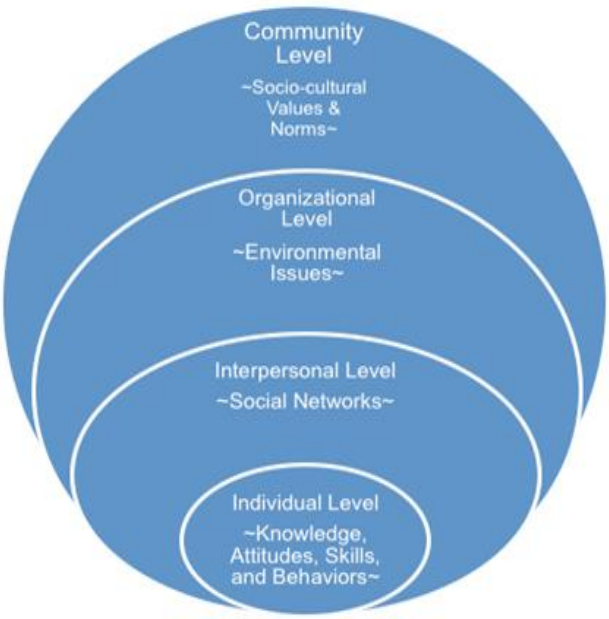

Figure 1: Socio-Economic Model of Health (SEM)

III. Deconstructing Psychological Reslience

Resilience is a complex concept that encompasses physiological responses, psychological, cultural and spiritual characteristics which may determine how a person will respond and function in times of stress (Resilience Alliance, 2010). Resilience, according to the Oxford English Dictionary, is "the ability to rebound or spring back, the power of something to resume its original shape or position after compression or bending," (OED online, n.d.). In philosophical terms, it can be understood within a concept of conatus: a word variously translated as striving, endeavor, tendency and effort, and also with meanings related to power, will, and desire. Conatus is an essential attribute of all things, and in particular of human beings. It is our striving towards self-maintenance. Each thing, in so far as it is in itself, endeavors to persevere in its being (Garrett, 1996). For health researchers, resilience is an interactive concept which refers to the capacity for successful adaptation in adversity, the ability to bounce back after encountering difficulties, negative events or hard times (Rutter, 2006). It includes a sense of self-esteem or self-confidence, patience and the ability to adapt to changing circumstances, humor in the face of difficulties and a belief that problems can be solved (Connor & Davidson, 2003). It is the process of adapting well in the face of emotional difficulties, adversity, trauma, tragedy, and overwhelming or unrelenting stress that reflects personal and social cognition.

Higher resiliency in individuals with mental illnesses is associated with better treatment response and outcomes; and individuals with high resiliency report lower psychopathology, while individuals with low resiliency report more psychopathology (Campbell-Sills, Cohana, & Steina, 2006). Wrenn, et al. (2011) conducted a study with results that suggest a role for assessing resilience in highly traumatized primary care populations as a way to better characterize risk for PTSD and direct screening/psychiatric referral efforts. Among individuals at-risk for mental

illnesses, including depression and PTSD, we contend that consideration of resilience as a protective factor may be enhanced by psycho-educational training for African American women to strengthen this construct. We propose that resilience is a protective factor for African American women at risk for mental illnesses, including PTSD. Core concepts of resilience (see Figure 2) are: 1) optimism and perseverance, 2) personal competence and tenacity, 3) social competence and support, 4) emotional awareness and tolerance of stress, and 5) internal locus of control (Siebert, 2005).

Figure 2: Core Concepts of Reslience

Characteristics of Reslient People

According to Tugade & Fredrickson, 2004, some of the common characteristics of resilient people include:

- They have a sense of meaning, direction, and purpose. They are value-centered rather than reactive and defensive.
- They realize that the quality of our lives depends on how we focus our energy and our attention. They try to align their thoughts and actions with their values. They know how to motivate themselves to take action.
- They don't judge themselves or others harshly when things go wrong. They focus on what they want, not on what they don't want.
- They are able to tolerate ambiguity, uncertainty, and imperfection. They have a long-range perspective, so they give themselves and others room to grow. They can afford to be flexible and creative because they are centered in their values.
- They are reasonably optimistic. Even though they are dedicated to doing things well, they do not take themselves too seriously.
- They take responsibility for their mental programming, their emotions, and their actions. If they have ineffective ways of thinking and behaving, they evaluate them and make appropriate changes.

- They look at adversity as a challenge rather than as a threat. They realize that no matter how the present situation turns out, they will learn and grow from it.
- They respect themselves and other people.
- They have a spirit of cooperation, looking for win-win solutions rather than trying to win over other people or ignoring their own wants and needs because of fear.
- They are grateful for the good things in their lives.
- They know how to let go of things they have no control over.

Use of Psychological Resilience as a Model for Coping with Mental Illness

Strengthening psychological resilience among African American women at risk for mental illness within a primary care setting is promising (Holden, Bradford, Hall, & Belton, 2013). The challenge of how best to cultivate psychological resilience in the face of stress, trauma, and/or social adversity among disadvantaged populations is a complex, understudied question with few evidence-based answers. The effectiveness of existing therapies for treating symptoms of PTSD and Major Depressive Disorder (MDD) are demonstrated in extensive meta-analyses (Van Etten & Taylor, 1998; Bradley, Greene, Russ, Dutra, & Westen, 2005). African American women with PTSD are understudied and underrepresented in treatment populations despite increased exposure to trauma and risk for mental illnesses; and available studies suggest they are more likely to drop out of treatment (Matthieu & Ivanoff, 2006).

Although clinician racial pairing may improve treatment engagement, this is not always feasible, and strengths based intervention may be more effective in engaging this population (Zimmerman, 2013) additional factors that may impact treatment engagement among disparity populations include identification of subthreshold PTSD impairment and comorbidity (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Zlotnick, Franklin, & Zimmerman, 2002). This is particularly relevant as many individuals impacted by trauma and depression may be receiving primary care, but not specialty mental health care (Spoont, Sayer, & Nelson, 2015). In terms of a preventative approach, the Agency for Healthcare Research and Quality (AHRQ), through its Evidence-based Practice Centers (EPCs) conducted a systemic review of the evidence for interventions designed to prevent development of posttraumatic stress disorder after exposure to psychological trauma (Gartlehner, Forneris, Brownley, Gaynes, & Sonis, 2013). Overall they found that evidence was limited, but brief trauma-focused cognitive behavioral therapy (CBT) and collaborative care had evidence of efficacy over supportive counseling and usual care respectively. Moreover, in a qualitative study conducted by Holden, Belton, & Hall (2015), African American women were asked: *What treatment strategies do you think may contribute to African American women to cope better with depression?* The following categorical responses were provided: (1) psychotherapy, (2) counseling, (3) support groups, (4) living a healthy lifestyle, (5) spiritual fellowship and religious worship, and (6) education about how to deal with stress and life problems.

It is clear that stress, depressive symptoms, and trauma are prevalent among African American women, who share a disproportionate burden of illness in part due to disparities in treatment seeking behavior and access. In fact, the rates of PTSD and comorbidity are substantially higher in urban settings, with a lifetime prevalence estimated at 60% among African American women (Alim et al., 2006). PTSD can best be understood as an aberrant stress response to a life-threatening event that is characterized by the core symptoms newly defined by the Diagnostic and Statistical Manual, Fifth Edition: (1) intrusion symptoms of memories, dreams and reactivity to cues, (2) avoidance symptoms of memories, thoughts, feelings, and reminders, (3) cognition and mood symptoms that are distorted, negative, and diminished in interest, (4) arousal and reactivity symptoms in hypervigilance, startle, irritability, and deficient concentration and sleep.

PTSD along with MDD are debilitating conditions, yet qualitative examination of illness experience and help seeking decision making suggests that African American women are willing to endure severe symptoms, and have a tendency toward downward comparison (referring to those that are worse off) and engage historical survivorship narratives in a maladaptive fashion (my ancestors went through much worse, I should be able to handle things) (Wrenn

et al., 2013). The existing system of mental health treatment does not provide culturally centered interventions that adequately engage African American women to support navigation of culturally-based, strength-identity values that directly conflict with an illness narrative. Holden et al. (2012) reported psychosocial and socio-cultural issues that may elevate African Americans risk for depression and identified strengthening the construct of resilience as a promising coping method. By understanding the role of resilience in recovery from depression, adverse experiences, improved treatment and interventional methods may be developed.

IV. Promising Psycho-educational Resilience Training Models for African American Women

The Network-Episode Model of mental health help seeking recognizes the importance of social influence in facilitating self-referral to treatment, and initiatives such as Mental Health First Aid are designed to increase awareness of conditions such as Depression and PTSD. However, for those individuals who are unable to maintain a resilience narrative due to symptom severity and functional impairment, new wave therapies are most promising (Hayes, 2004). The central goal of New Wave therapies is to restore capacities. Thus, Linehan (1993) recognized the need for emotion regulation and incorporated Zen Buddhist meditation to encourage acceptance, mindful awareness, and tolerance of symptoms rather than their change (Linehan, 1993).

Seeking Safety is a trauma-informed, strength-based intervention centered on constructs of cognitive behavior therapy (CBT); and other approaches identified social skills training and emotion regulation (Jacobson, Martell, & Dimidjian, 2001; Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2006), behavioral activation in depression, well-being therapy to treat residual symptoms of depression and anxiety (Fava, 2003), mindfulness training for observation of thoughts without judgment (Teasdale et al., 2000), and Acceptance and Commitment Therapy (ACT) of Hayes (2004) for the pursuit of valued goals as a main therapeutic approach. Narratives of exceptional survival in extreme situations are characterized by engagement with their circumstances in ways that kept individuals well, by social relatedness, and by an efficient stress response.

Psychological interventions designed to promote engagement in specialty care, prevent negative consequences of stress or trauma that are based in primary care or community settings, and building resilience to cope with depressive symptoms are promising. Moreover, an essential and salient theme for interventions with African American women may be the use of culturally valid concepts of personal strength, community support for recovery, and resilience in the face of adversity. Moreover, two (2) promising psycho-educational curricula are: Goal Directed Resilience in Training (GRIT) (Kent, Rivers, & Wrenn, 2015) and Ladies First! (Holden & Bradford, 2013) as exemplar models.

Overview of Goal-Directed Resilience Skills Training

Goal-Directed Resilience Skills Training (GRIT) is a structured, manualized program that takes participants through four steps in which they re-experience past engagement and relatedness episodes and use these in simulations to transform trauma:

(1) Preparation: to allow participants to do the work of the program, a readily available calming response is required. Participants are asked to set traumatic experiences aside and find an episode from childhood or early adult years in which they are cherished and loved, or they cherish and love someone or something else. When stressed during the intervention, they are to return to this episode rather than remain stressed. Experiences of secure attachment restore feelings of safety even during high threat conditions and aid in healing trauma even when mobilized symbolically.

(2) The Elements: participants identify approach/engagement and social relatedness experiences from childhood and early adulthood. Since these experiences are not novel but are already biologically

established, they facilitate the re-experiencing of goal-directed responding and ground these in sensations. The view of memory as a construction made up of fragments of the past is particularly compatible with the 'simulated constructive' approach of the program. Participants have an opportunity to find relevant past fragments and fashion new themes out of them.

(3) Transformation: approach/engagement and social relatedness episodes are used in a return to traumatic events. As noted earlier, engagement activities of interest or curiosity and social activities in themselves are relatively pleasant and innocuous. However, they become tools for transformation when facing challenges, thereby demonstrating adaptive action and 'resilience'. In this constructive approach to memory and sensation, the past is rearranged into a recombined memory with goal-directed action that is grounded in sensation and a prospective direction to the future.

(4) The Future: the goal-directed approach/engagement and social relatedness are applied to designing a good life with resilient responses to possible future challenges. Participants' futures contain their own goals and interests and pathways to achieving them. Goal-directed engagement and relatedness are essential for flexible anticipatory adaptation capable of transforming reactivity. This process enables participants to create a new, resilient, and more integrated narrative of their lives that is rooted in their experiences and sensations.

A preliminary randomized controlled study of this intervention among 39 veterans with PTSD suggest that treatment explicitly targeting resilience resources (e.g., positive emotional engagement, social connectedness) may provide broad benefits, including alleviation of anxiety and depressive symptoms and improved positive emotional and cognitive function (Kent, Davis, Stark, & Stewart, 2011). In addition, a to be published pilot study of African American women with clinically significantly PTSD who had not sought treatment for their symptoms suggested that a resilience oriented intervention is culturally acceptable. Although more research is needed to test this intervention among ethnically diverse women, this is a promising intervention that can be culturally adapted to address the gaps in strengths-based interventions available to ethnically diverse women.

Overview of Ladies First!

Ladies First! is a 4-week psychosocial resilience empowerment intervention for African American women with depressive symptoms. The intervention sessions are based on a modified adapted version of a model developed by Dr. Al Siebert author of The Resiliency Advantage (2005) and an educational curriculum developed by the American Psychological Association entitled, The Road to Resiliency. This integrated program has been utilized by the Centers for Disease Control and Prevention, Office of Health and Safety. It is designed to be implemented by a mental health professional, and the intervention includes four sessions:

(1) African American Women and Depression

This session focuses on issues concerning the recognition of the signs and symptoms of depression; and identification of specific psychosocial, environmental, and socio-cultural that may be encountered by African American women which can elevate their risk for depression. The viewing of a 10 minute DVD, Black and Blue: African Americans and Depression (developed by Annelle Primm, MD) is included and the concept of resilience is introduced as a method to support individuals coping with depression.

(2) Building Psychological Resilience to Cope with Depressive Symptoms

This session centers on specific resilience-based strategies that can be incorporated into one's life to better cope with depression. It includes an introduction to various therapeutic mental health care considerations including use of behavioral health services provided by psychiatrists, psychologists,

social workers, and counselors; a discussion of barriers to treatment for depression; and identification of resources for community support. Emphasis is placed on encouraging participant's to build their psychological resilience to become more comfortable with seeking help for addressing their symptoms of depression from mental health professionals, and support groups that are offered by local mental health agencies and organizations.

(3) Resilience as a Tool of Empowerment.

This session emphasise self-empowerment and specific strategies that women can adopt to decrease unconstructive thinking patterns, improve feelings of self-worth, effectively manage stress, and incorporate personal spiritual based principles into approaches for coping with symptoms of depression.

(4) Developing Your Resilience Self-Care Action Plan for Handling Depressive Symptoms.

This session encourages participant's development of a personally tailored resilience based self-care action plan for handling their experiences of depression. Specific action oriented items and goals (short-term and long-term) are collaboratively developed for each woman.

Each of the intervention sessions have been developed using a culturally centered orientation to offer research participant's training in strengthening their resiliency that may be used as a tool of empowerment for coping with depression. The intervention uses tenets of the CRASH model of cultural competency (Rust, et al., 2006). CRASH is a mnemonic for – Culture, show Respect, Assess/Affirm differences, show Sensitivity and Self-awareness, and do it all with Humility. Tenets of selected psychosocial constructs (e.g., negative/ruminative thinking, stress, self-esteem, social support, and spirituality) are also infused in the sessions since these issues are important for consideration among depressed African American women. The sessions are designed to be interactive, and provide an opportunity to elicit an exchange of ideas and for participants to actively engage in the learning experience. Our goal is to use training methods that will lead to increased information, skills acquisition, and improved attitudes about selected psychosocial and mental health concepts that may be useful for participants. Workshop training methods will include: lecture style; role play; didactic interactions; interactive discussion; experiential processing; creative application of education materials; and small group work. All educational materials include images of African American women and include culturally centered information (i.e., quotes and affirmations by famous African American women).

More research is needed to establish the evidence base for mechanism of action and preventive value of these and other culturally centered approaches.

V. Strengthening Psychological Resilience

Building resilience is a personal journey that includes a combination of several factors, including: (1) establishing and nurturing healthy relationships that create love and trust, provide role models, and offer encouragement and reassurance, (2) demonstrating a positive view of yourself and confidence in your strengths and abilities, (3) harnessing skills in effective communication and problem solving, and (4) delineating the capacity to manage strong feelings and impulses. Moreover, there are several strategies that can be used to strengthen resilience among African American women. Some of the tools that may be useful include the following:

- Try to avoid viewing crises as insurmountable problems—you can't change the fact that highly stressful events happen, but you can change how you interpret and respond to these events.
- Try to look beyond the present to how future circumstances may be a little better.
- Try to acknowledge small and/or subtle changes in how you feel as time goes on; this may help you to better deal with difficult situations moderately.
- Try to learn from your past-focusing on past experiences and sources of personal strength which can help you learn about what strategies for building resilience might work for you.

VI. Conclusion

While the current evidence base remains dominated by symptom-driven, disease specific approaches to intervention, programs such as *Ladies First!* and *GRIT* are promising efforts that employ a resilience and recovery orientation to address depression and PTSD, respectively. Further, by integrating the individual's personal narrative and recognizing the potential of empowerment to support engagement in the illness recovery process, a continuum of care is created where psychological distress is replaced with hope, optimism, and a positive adaptation to adversity and stress. These methods are culturally grounded and consistent with a strength-based orientation highly valued among many racial/ethnic groups, including African American women. Given the increasing rates of depression and PTSD, persistent gaps in treatment seeking, and challenges with access to specialty care, strategies to increase resilience and promote recovery are necessary to improve the overall health of communities and populations. We contend that strengthening psychological resilience among diverse African American women at risk for depression and/or PTSD may serve as a protective factor for symptom severity. Multidimensional prevention and intervention strategies should incorporate culturally-centered, gender-specific, and strengths-based (resilience) models of care to help encourage mental health help-seeking and promotion of wellness for African American women.

Research Implications

Research has a major role in establishing scientific evidence for building a solid foundation for the implementation of interventions that may aid in reducing mental health inequities, the impact of trauma and violence, and ways to support diverse modalities of coping (e.g., resilience training). We must design, implement and evaluate resilience-based models to support innovative ways to reduce mental illnesses such as depression and PTSD for at-risk African American women. Inventive, community-based, socio-cultural, psychiatric, clinical and translational investigations are needed. These research studies must explore the complexities and intersection of multi-dimensional variables, bio-psycho-social issues, and cultural topics that help to elucidate considerations about ethnically and culturally diverse groups. Better dissemination of research outcomes/findings to and from various local, national, and international communities by using inventive strategies will help to promulgate information to promote health. Furthermore, it is critical that prevention, intervention efforts, and health educational programs use bi-directional science discovery, evidence-based models, and intentional community engagement to encourage behaviors and practices that advance improvements in health. Working collaboratively with scholars, researchers and public health care professionals from diverse communities *versus* simply gathering data from their own local communities is a critical step in nurturing trust, strengthening credibility, and building strategic partnerships.

Policy Implications

Prevention of mental illness and mental health promotion need to be an essential part of public health and health promotion policies at local and national levels. While African American women share a disproportionate burden of mental illness, they are more likely to be misdiagnosed, underdiagnosed, and undertreated for these illnesses. The interventions presented in this paper demonstrate that training models of psycho-educational resilience may be

instrumental in assisting African American women in coping with mental illness. However, to facilitate effective implementation of such interventions require that conditions are met locally and nationally.

Funding agencies and policy makers should increase support for multifaceted programs and interventions that are culturally tailored and strengths based for culturally diverse populations. Historically, the mental health system has not effectively addressed the needs of culturally diverse populations, which has contributed to racial and ethnic disparities in mental health access, availability, and utilization. While there are a multitude of factors that contribute to mental health care disparities, a frequently cited factor has been the inability of the mental health system to understand the cultural and contextual needs of diverse populations and adapt services accordingly.

Greater funding support is required for rigorous program evaluation to better understand the efficacy of resiliency training programs and to provide information that can benefit decision makers in directing future study. To date there are a limited number of resilience-based intervention studies, particularly those conducted with diverse populations and in diverse settings. (Leppin et al., 2014)

Poorer mental health among African American women may be mitigated by improving access to comprehensive, integrated and patient-centered quality health care. There should be better integration of screening to increase appropriate identification of mental illness, assessment, and support for African American women in a primary care clinic. Additionally, there should be monitoring on the ongoing implementation of the integration of behavioral and medical care and other state and congressional actions to ensure that Black women's mental health needs are being addressed and met.

Mental health professionals, particularly those from diverse populations, should serve as advocates, to ensure equitable treatment for all including psycho-educational resilience training models for African American women. Mental health professionals are well placed to increase awareness and information on appropriate prevention and treatment among policy makers, other professionals and the general population, to create an environment that is more conducive to prevention and treatment efforts such as resilience based interventions.

Resilience-based interventions should be integrated within a public policy approach that considers factors that influence mental health disparities, including social determinants of health such as poor education, lack of health insurance coverage, economic challenges, and impoverished environmental conditions. An example could be incorporating resilience-based training into the benefits systems. Benefit systems are based on two core areas, income support and unemployment/activation benefits. Users in both areas may have mental health illnesses, and benefit systems need to be designed to respond to their needs at different moments of people's lives.

Finally, African American women would benefit from more opportunities to be informed about the various mental health treatment programs available, particularly those that are culturally tailored and strengths-based. A resource guide, coupled with community-based educational events would increase awareness about the different treatment options available to this diverse population.

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