Overcoming Barriers to Conducting an Intervention Study of Depression in an Older African American Population

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Abstract

The purpose of this article is to describe barriers and strengths of a study testing the effects of reminiscence on depressive symptoms in community-dwelling older African Americans. Primary data sources included debriefing sessions, reflective journals, participant observations, and key informant interviews. Data were analyzed using immersion/crystallization technique. Mistrust between gatekeepers and universities, recruitment and retention of research assistants and participants, culturally insensitive instruments, and stigma associated with depression were barriers. Successful approaches used to overcome the barriers experienced by the research team are described. Implications for transcultural nursing research and practice are discussed.

The United States Census Bureau predicts that by the year 2030, older African American adults will represent the highest number of minority elders in the United States. This expected rise in the older African American population has major implications for the mental health care delivery system. For example, according to National Institute of Mental Health (2003), an estimated 2 million of the 35 million older adults in American have a depressive illness and another 5 million have subsyndromal or minor depression. The consequences of untreated depression in older adults includes increased mortality, suicidal ideation, and decreased functional abilities (Cook, Pearson, Thompson, Black, & Rabins, 2002; Fröjdh, Håkansson, Karlsson, & Molarius, 2003). It has been shown that older minority groups are less likely to access depression treatment than their White counterparts (Crystal, Sambamoorthi, Walkup, & Akincigil, 2003). Specifically, African Americans are more likely to be underdiagnosed and undertreated for depression than other ethnic groups (Das, Olfson, McCurtis, & Weissman, 2006).

The inequities affecting depression treatment of older African Americans are the result of having less access to mental health services, receiving poorer quality of care, and an underrepresentation of minorities in mental health research (DHHS, 2001). The barriers to African American participation in research studies have been cited to be power differences between researchers and research participants, insufficient recruitment efforts, mistrust of the intentions of academic institutions, overall uncertainty about the research process and inadequate support of research participants (Dancy, Wilbur, Talashek, Bonner, & Barnes-Boyd, 2004;

Lichtenberg, Brown, Jackson, & Washington, 2004; Mason, 2005; Outlaw, Bourjolly, & Barg, 2000). Compounding the challenges to recruitment and retention of older African Americans in depression studies is that depression is a disorder that is often stigmatized in the African American community (Sanders Thompson, Bazile, & Akbar, 2004; Shellman, Mokel, & Wright, 2007). Findings from research studies suggest that African Americans look negatively on mental illnesses such as depression and that individuals diagnosed are abandoned by their relatives or negatively labeled (Lorant et al., 2003; Sanders Thompson et al., 2004). These findings also suggest that African Americans generally have distinct beliefs about what causes depression and therefore, what is appropriate treatment. In particular, some studies have shown that African Americans believe that depression is a personal weakness and the result of improper lifestyles (e.g., too much worry, working too hard, not being pious enough) or negative thinking and is a condition that medicine cannot cure or should not even address (Egede, 2002; Shellman et al., 2007). This perspective poses some practical problems when recruiting older African Americans to participate in depression studies. Given these held beliefs

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about depression by African Americans suggest the health care options for prevention or treatment of the problem must be based on thorough knowledge and collaboration of patient, family, and reference groups such as churches, senior centers (Cooper, Brown, Vu, Ford, & Powe, 2001; Sanders Thompson et al., 2004).

With the increase in the older African American population and inequities surrounding depression research and treatment in this population, there is a critical need for the development and testing of culturally acceptable and cost-effective therapeutic depression interventions. Even though the need for conducting depression studies with older African Americans has been identified, conducting research in this area is complicated. In an article describing issues and problems underlying research with minority groups, Sue and Dhinda (2006) call for researchers to adequately address methodological difficulties that are associated with conducting studies with different ethnic groups to improve health inequities research. The overall goal of the process evaluation described in this article was to assess for barriers throughout study implementation. These data will inform the next phase of the reminiscence research program to conduct a larger scale study that tests the effects of reminiscence on depressive symptoms in older African Americans. The specific aims for the evaluation phase were

1. to describe the challenges and successes associated with conducting a pilot study to test the effects of an integrative reminiscence intervention on depression and life satisfaction in a sample of older African Americans, and
2. to determine the feasibility and acceptability of an integrative reminiscence intervention to decrease depressive symptoms in a sample of older African Americans.

Background/Pilot Study Description

As identified in the aims, this process evaluation seeks to illuminate important issues discovered while conducting an integrative reminiscence intervention study with older African Americans. The pilot study undergoing the process evaluation used a pretest, posttest, randomized control design to assess the effectiveness of an integrative reminiscence intervention on depression and life satisfaction in a sample of older Africans Americans. Integrative reminiscence is a process used by older adults that is characterized by identifying a supportive listener and validating the older adult's life experiences, acknowledging past coping skills, and emphasizing accomplishments (Watt & Wong, 1991).

A three-group pre- and posttest design was used in the pilot study and included a reminiscence group, health education group, and a true control group. The reminiscence sessions lasted 45 minutes, participants met with the research assistant for 1 hour a week for 8 weeks. The health education groups met for the same amount of time, and the control group was offered the reminiscence session once the study had been completed. The target population was older African Americans older than the age of 60 born in the United States. Research participants were recruited from community senior centers, churches, and senior housing projects.

The research team consisted of African American research assistants (RAs) and the White principal investigator (PI). African American RAs were selected to collect the data and conduct reminiscence because shared group membership has been described as a way of facilitating discussion and disclosure of sensitive topics (Brach & Fraserirector, 2000) and inclusion of researchers who belong to the ethnic group under study has the potential to reduce the threats to a valid research process (Porter & Villarruel, 1993). The RAs were trained by the doctorally prepared nurse researcher to administer forms, conduct culturally sensitive interviews, and maintain reflective journals. Additionally, all RAs participated in the protection of human subjects training required by the university. The African American RAs were assigned to collect data, facilitate the reminiscence intervention, or conduct the health education sessions to avoid contamination during the research process. Results and a full description of the reminiscence intervention study are published in a separate article (Shellman, Mokel, & Hewitt, 2009).

The Process Evaluation

From the start of the study the research team collected process data for the following reasons: (a) ensure adherence to procedures and processes thus improving the reliability and validity of the study and (b) discover barriers that could be identified to prevent them from occurring in future studies. Process evaluation (or formative evaluation) consists of quantitative and qualitative assessments that provide complementary data on the strengths and weaknesses of the program (Trochim, 2006). Data for this process evaluation were collected from April 2004 to June 2007 during recruitment, data collection, and implementation of the intervention. RAs were trained to collect process data throughout the study. Primary data sources included (a) debriefing sessions with nurse researchers, (b) reflective journals, (c) participant observations, (d) audio tapes, and (e) key informant interviews conducted with senior center directors, pastors, and church group leaders. The debriefings sessions were held weekly either person to person or via phone. These data assisted the PI to assess and discuss recruitment and retention issues, data collection, and fidelity of the reminiscence intervention. Research assistants were encouraged to write their reflections in a journal as soon as possible after data collection or the reminiscence sessions. Participant observations were conducted throughout the study to gain insight into the population. Using the framework of Bogdewic's (1999) method

of participant observation, researchers conducted participant observations to observe behaviors and establish rapport by participating in activities such as bingo, lunches, and blood pressure clinics in the churches and senior centers. Finally, key informant interviews were conducted to obtain a historical perspective of the communities as well as information regarding the reminiscence study as it progressed.

Data Analysis

Demographic characteristics and descriptive data were analyzed using SPSS 15. The research team documented the challenges, successes and limitations of recruitment, retention, data collection, and the reminiscence intervention. Through continual analysis of the research process during debriefing sessions, strategies for overcoming the challenges were developed and recommendations for the larger study were made. Contextual data from reflective journals, participant observations, audio tapes, and key informant interviews were analyzed using the immersion/crystallization (IC) technique described by Borkan (1999). This interpretive technique is intuitive, more engaged, and more fluid during all stages of the research process from conceptualization of the project to the description of results. The steps to this analysis process are (a) initial engagement with the topic, (b) crystallization, (c) immersion and illumination from collected data and texts, (d) explication and synthesis, (e) consideration of alternative interpretations, and (f) reporting the account. Analysis is constant, reflective, and there is a repeated delving into and experiencing of the data throughout the study (Borkan, 1999). This analysis was selected because IC occurs before data collection, during the study design and planning, during and after data collection, and as the write up or reporting is completed. This continuous analytic technique fit well with the specific aims of the process evaluation.

Feasibility and acceptability were measured by retention of participants in the reminiscence intervention, and contextual data collected from the participants after the reminiscence sessions were complete.

Results

Sample

Eight different sites were approached during recruitment sessions. Adults aged 52 to 91 years were enrolled. Table 1 describes the demographic characteristics of the sample. It should be noted that originally it was expected that only adults older than 60 years would be included in this study. As participants finished the study, they began referring other potential participants to the research assistants. This was an unexpected, but a welcomed recruitment method. Four of the referrals were younger than 60 years.

Table 1. Age, Birthplace, and Gender Characteristics of the Sample

	N (56)	Percentage	Mean
Age in years			72.3
(range = 52-91)			
52-60	4	7.2	
61-70	20	35.9	
71-80	23	41.3	
81-90	8	14.4	
>90	1	1.2	
Birthplace (region U.S.)			
Northeast	18	32.1	
South	36	67.3	
Other	2	3.6	
Gender			
Male	13	23.2	
Female	43	76.8	

Because the recruitment process was lengthy and difficult, we decided to open the study to adults aged 50 years and older.

Additional social and demographic characteristics indicate that 41% of the participants had completed high school education. In all, 14% of the participants reported income that fell below the 2007 Federal Poverty Guideline levels. Most participants were churchgoers with more than half (59.7%) attending church for more than 45 years. Few participants (6.2%) reported that they never attended church. More than half (56%) of the participants lived alone and approximately one third (32%) lived with their spouse.

Process Evaluation Findings

The IC approach revealed many insights and illuminations during the study. Valuable "in process" analyses occurred frequently during the pilot study. Table 2 presents an example of in process analysis using the IC approach. For example, during the initial engagement phase the topic of depression in African Americans was reflected on and discussed by the research team. This allowed the data collector to be open and receptive to the experience. Subsequently, the research assistants made important observations about the depression in this sample while collecting data. Participants' actions and emotions were not corresponding with how they answered the Center for Epidemiologic Studies–Depression Scale (CES-D) items. The RAs observed depressive symptomatology, but participants reported the opposite. Because this was a pilot study, collecting these data led to changing the protocol from a cut off of a score of 16 on the CES-D to allowing all volunteers into the study. The research team then decided to ask the participants about their thoughts and beliefs about depression. The contextual data collected gave the research team

Table 2. Example of Insights Gained During Study Using Immersion/Crystallization Approach

Stages of the Immersion/ Crystallization Approach	Process	Example of Insights/Interpretations
Initial engagement	Recording/discussion of biases with research team	Biases toward older adults and depression
Describing	Field notes Debriefing sessions with research team	Participants scoring zero or low depressive scores while expressing flat affect, crying
Crystallization	Insights gained during the study	Participants scores not reflective of what research team, key informants are observing
Immersion/illumination	Reviewing data repeatedly	Patterns of low depressive symptom scores led to need for more in-depth interviews about beliefs and attitudes toward depression
Consideration of alternative interpretations	Reviewing insights with research assistants and colleagues	Senior center directors, church group leaders report depression as a problem with seniors and confirm insights/interpretations
Reporting	Manuscript development Discussion of findings with participants	"Keeping the Bully Out" Older African Americans Beliefs and Attitudes Toward Depression (Shellman et al., 2007) Use of different methodology in future depression intervention studies with older African Americans

greater insight into the stigma associated with depression in this sample of older African American adults (Shellman et al., 2007).

The insights and illuminations gathered and described during the study emerged into the following four major categories: (a) recruitment issues, (b) mistrust, (c) cultural appropriateness of screening instruments, and (d) intervention/implementation.

Recruitment Issues

Research assistants. African American nurse RAs were recruited because research suggests that involving researchers from the same ethnic group is one way to ensure cultural competency in research, as well as to provide a way to facilitate discussion about sensitive topics (Brach & Fraserirector, 2000). Recruitment and training of research assistants began in the spring of 2004. However, the study did not begin until late fall of 2004 because of difficulties recruiting and retaining research assistants. Over the course of the study, 12 African American RAs were recruited and trained. Originally, nursing students were recruited, but because of the small pool of available African American nursing students and RA attrition, the pool was broadened to include non-nurse RAs outside of the sponsoring university, including a social worker, a high school teacher from an area high school, and a supervisor at an area business. This unexpected challenge stabilized once an African American doctoral student was hired. The doctoral student met her research internship requirement while providing consistency to the overall study.

Participants. Once African American RAs were hired, recruitment of participants began. A total of 187 older African Americans were approached over a 2-year period. The PI, a community health nurse, had developed relationships with

community agencies such as senior centers and churches by conducting blood pressure clinics at these sites. Even though the PI had begun the partnership and was granted permission by gatekeepers to conduct the study, once participants were informed that the study topic involved depression, 12 of the first 20 (60%) potential participants dropped out of the study stating "not enough time," "I am not depressed," and three potential participants reported that their family members did not want them to participate. To strengthen our relationship, the research team began to conduct wellness screenings, and attend lunches at the senior centers on a weekly basis. However, the recruitment process took 2 years to attain the final sample of 56.

One unexpected challenge that affected recruitment of participants was the age differences between the participants and research assistants. Even though African American RAs were hired, their age was a factor in whether the older adults participated or not. Key informants reported that older African Americans were hesitant to talk about their experiences with younger people. This challenge worked itself out through time and with the hiring of older RAs working in other professions such as education and business fields. Additionally, the RA conducting reminiscence reported that this hesitation to work with younger people lessened with each reminiscence session.

Community contact persons or "gatekeepers." RAs made several attempts to recruit individuals at local area churches and community centers with little success. In response to a recruitment attempt, one contact person said, "I'll give them your information but I'm sure they won't be interested . . . we have all the services we need here." In another church, contact was made with the pastor, who expressed some interest in the study but after repeated attempts to contact her, she did not follow through. Additionally, RAs would set up meetings for the PI to meet with gatekeepers

at potential sites. During the debriefing sessions, RAs would report a "different, more protective attitude" among gatekeepers once they met the White PI researcher from the university.

Eventually, as different RAs were hired, their networks became key in recruitment of sites. Additionally, the PI continued visiting the sites and talking with the gatekeepers. One senior center director reported, "you kept coming back when you said you would." This, in addition to the director's reports of other universities coming in to conduct research and leaving were the reasons for initial mistrust of the research project. Several individuals from the community became actively involved in the project and served as crucial resources for potential participants. In all, 15 of the 56 final participants were recruited through this route.

Mistrust

Despite training and creating a presence before the study began, the team was not prepared for the degree of mistrust expressed by participants and gatekeepers. This mistrust expressed itself with refusals to participate, hesitancy to complete surveys, and extensive questioning by gatekeepers during initial meetings. In one urban setting, three church groups expressed a great deal of concern about allowing research to be conducted with their members. Not only was the PI's motive in question, but past experiences with universities conducting research had left the churches with feelings of being used. The African American RAs also reported feelings of mistrust to the PI during the debriefing sessions. For example, during data collection one participant stated, "why do you need to know this?" Another participant asked, "are you going to use me like a lab rat."

Screening Instruments

The Center for Epidemiologic Studies–Depression Scale (CES-D). The CES-D is a 20-item, reliable and valid instrument for use with older African Americans. Coefficient alphas >.85 and test–retest correlation ($r > .5$) were reported for older African American populations (Baker, Velli, Freidman, & Wiley 1995; Roberts, 1980). The CES-D is a survey instrument used to identify depressive symptomatology (Radloff, 1977). Scores can range from 0 to 60 with higher scores denoting more depressive symptomatology. Despite what the literature shows, screening of potential research participants for depressive symptoms initially was a challenge. Participants completing the CES-D scale gave positive responses to all of the statements, initially resulting in low scores. for many participants. On average, early participants completing the scale uniformly received a score of 0.

Use of Life Satisfaction Instrument. The Life Satisfaction Index-A (LSIA) is a reliable and valid 20-item scale that measures life satisfaction and has been consistently with older populations aged 50 to 90 years. One study showed that the scale was highly reliable in measuring life satisfaction among African American elders (Rao & Rao, 1982). Participants completing the LSIA consistently had issues when responding to some of the statements on the scale. For example, two of the statements, "compared with other people my age" and "the *lot* of the average man" presented problems for the participants. Uniformly, when presented with the first statement, participants stated that they "didn't compare (themselves) with someone else" and that the statement was difficult to answer. The second statement, regarding the *lot* of the average man was one that had to be restated or rephrased for several participants before they responded. The participants expressed dissatisfaction with the wording of the scale throughout the study.

Reminiscence as an Intervention With Older African Americans

Even though the recruitment process was lengthy, there was little attrition from the participants once they were randomized in the reminiscence group. One participant in the reminiscence group dropped out reporting, "my family does not want me to participate." Evaluation data gathered from participant observations, debriefing sessions, and research journals demonstrated that (a) the participants enjoyed reminiscence, (b) reminiscence assisted with trust building, (c) reminiscence can be a tool for learning about cultural perspective regarding health beliefs, and (d) participants enjoyed reminiscing among themselves. Facilitating reminiscing initially required some prompting for it to occur naturally. In general, it took about two reminiscence sessions before most participants reminisced freely about their lives, although several participants were immediately comfortable with reminiscing. Of those few, they mentioned that they "looked forward to the sessions" and that they enjoyed the reminiscing with the research assistant. One participant commented, "I led an interesting life but never had a chance to talk to anyone about it because no one asked." Additionally, the RAs noted time and again that with each reminiscence session the participants began to share more intimate details of their lives. The assistants felt a deeper level of trust had developed through reminiscence.

Many participants shared some of their beliefs about health and disease causation. Beliefs about the origins of mental and physical health issues as well as the appropriate treatment emerged frequently during both reminiscence and health education sessions. For instance, one participant confided that she opted to take "natural" remedies for her diabetes instead of the prescription from her doctor. She stated that the prescriptions were, "not natural, God did not make those drugs." The belief that God controls the course of illness and aspects of religion such as prayer and faith

often presented as important resources in the lives of these individuals.

Discussion

The most critical challenges found while conducting this study were the level of mistrust that had been developed between gatekeepers and universities before the study was undertaken, recruitment and retention of RAs and participants, administration of instruments, and the stigma associated with depression in this population. The challenges of recruitment and retention, stigma of depression, and mistrust, found in this study with older African Americans are supported by the work of Arean and Gallagher-Thompson (1996), Connell, Shaw, Foster, and Norman (2001), and Corbie-Smith, Thomas, Williams, and Moody-Ayers (1999). The most promising finding in the study was the use of reminiscence as an intervention. Although the aim of the study was to test the effects of reminiscence on depressive symptoms and life satisfaction, as the study was implemented it was noted that the reminiscence sessions provided a way for the development of trust between the researchers and participants. Additionally, reminiscence was found to be an effective intervention, not only for decreasing depressive symptoms but also for increasing knowledge about African American health beliefs. Other successes found through the data collection process included identifying the sources of strength and support that the participants provide for one another, better understanding of perceptions of depression in this sample, and the development of a trusting relationship between the research team and the senior centers and churches.

Developing trust is important when conducting research with diverse populations (Daunt, 2003). Although the research team expected some mistrust of the research process at first, we were not prepared for the degree of mistrust and hesitancy toward their participation in the study. Although the research team had made a presence through blood pressure screenings and participation in education session, we were not aware of their past relationships with certain academic institutions. It has been shown that minority populations often feel anger and mistrust toward academic institutions because funded researchers complete their research with little or no feedback to the community (Dancy et al., 2004). In this urban area, the research team was met with hesitancy and quickly learned that universities had conducted research without providing any feedback to the participants. For example, one pastor reported, "universities come in do their research and then we do not see them ever again." On learning this, the research team began to involve the gatekeepers (pastors, directors) in decision making and the RAs began reporting on a weekly basis about the status of the study. Once some level of trust was established with the gatekeepers, researchers were better able to immerse themselves in the community, by attending community events, developing close relationships with the

participants, and give back to the community by conducting educational sessions and luncheons for the senior centers and churches. Gatekeepers played a significant role in recruitment. For example, one gatekeeper said, "if I say that the study is okay, then they will know that everything is alright." Several participants were referred through gatekeepers who were familiar with different individuals at the selected sites. Invariably, these individuals provided much needed access to the research participants and facilitated development of a relationship within these communities.

The research team included three African American RAs and a White PI. It has been shown that including both insiders and outsiders on the research team would assist with recruitment, building trust, and greater insight into findings (Julion, Gross, & Barclay-McLaughlin, 2000; Porter & Villarruel, 1993). The PI worked to foster a team approach and create trust between by including the RAs in decision making and holding weekly debriefing sessions. This approach was successful in that three of the RAs presented findings at local and national nursing conferences and assisted with manuscript development. However, academic schedules, family responsibilities, and other challenges such as heavy course loads prevented long-term participation in the study. The experiences in this study with the African American nursing students indicated that it was not a matter of them not wanting to serve as RAs; they simply had too many barriers and other responsibilities that hindered their participation. Additionally, the attrition rate of minority nursing students is high (Crow, Smith, & Hartman, 2005). This left the PI with a small pool of potential African American nursing students to draw from. These data provide further evidence that there remains a need for schools of nursing to commit to retention of minority students through mentoring of faculty and students, financial assistance, and educational resources to promote success (Gilchrist & Rector, 2007).

The use of culturally relevant data-gathering instruments is necessary as researchers expand investigations to community-based minority older adult populations. Many times instrument development or validation techniques are not adequate enough to determine whether an instrument is appropriate for use with minority populations. Therefore, measurement error may occur through cultural differences in the understanding and interpretation of the meaning of concepts and items used to measure constructs (Gierl, 2000; Moors, 2004). Even though the CES-D and LSIA have been shown to be valid and reliable measures (Baker et al., 1995; Lobello, Underhill, & Fine, 2004) with African Americans, we found that administration of both scales presented some possible language and sociocultural issues, which pose reliability problems with this population. Presenting the instruments, even those found to be reliable and valid in other studies to the participants before the study to assess for cultural relevance and appropriateness of the particular sample would increase reliability and validity of any study.

According to a meta-analysis conducted by Pinquart, Duberstein, and Lyness (2007), reminiscence has been shown to be an efficacious intervention to decrease depressive symptoms in general populations of older adults. The pilot study described in this article is the first known reminiscence study specifically conducted with older African Americans. Feasibility was demonstrated in the low attrition rate in the reminiscence intervention group and acceptability was shown through contextual information provided by the participants. These data are supported by a qualitative study conducted with African American older adults (Shellman, 2004). Despite the numerous barriers faced by the research team, reminiscence proved to facilitate levels of trust and willingness to participate in research projects.

The issues of mistrust, age differences between participants and research assistants, lack of culturally appropriate instruments and resistance to participation in mental health studies has led this research team to conclude that creating a sustainable reminiscence intervention program would require a new approach centered on increased community participation. The use of community-based participatory research (CBPR) is one way to foster relationships and improve health through research. CBPR is an interactive approach between researchers and participants from a given community that allows data and information to flow back and forth between these two entities. Benefits of using CBPR are that the research topic (a) reflects concerns of the community; (b) enhances the relevance and application of the research data by all stakeholders; (c) brings partners with different skill levels, knowledge, and expertise together to address complex issues; (d) increases the quality, validity, sensitivity, and practicality of research by incorporating the knowledge of the participants; and (e) increases the possibility of overcoming the mistrust of research that regards communities as "subjects" (Israel, Eng, Schulz, & Parker, 2006). In this study, the research team learned over time that involving members of the community, especially gatekeepers, was vital to study implementation and retention of participants. It is proposed that a CBPR approach would overcome challenges that presented during the study. For example, approaching stakeholders and participants before the study was designed to create infrastructures for research partnerships, build common goals for the research, pilot test consent forms and instruments, and train community members to participate in all aspects of the research (Schensul et al., 2006).

Findings from this process evaluation have implications for transcultural nursing research and practice. Community-based participatory research may be a way to mitigate the factors that have resulted in reluctance among African Americans to participate in research studies. These factors include a history of discrimination, negative experiences with health care delivery and research, and cultural differences (Dennis & Neese, 2000). Based on this process evaluation, these factors do exist. Ministers and families of older adults act as gatekeepers to protect their members because of lack of trust in the researchers and research process. Although stricter safeguards have been implemented in recent years to protect human subjects, these safeguards have not erased the fear among African Americans that they may be taken advantage of for the sake of research. Additionally, many research studies do not look at the strengths of African Americans to overcome health disparities. Instead, research is undertaken to see how they are different from Whites (Rooks & Whitfield, 2004). The use of reminiscence focuses on the strength of the African American oral traditions. The major functions of folklore and storytelling include cultivating a harmonious African American community, sustaining their unique cultural identity by enabling people to have a clearer picture of their lives (Cannon, 1995; Stewart, 1997). As a result of this pilot work, the research team and community stakeholders are using a CBPR approach to develop a peer reminiscence program using the strengths of storytelling and peer support to decrease depressive symptoms in this population.

Finally, transcultural nurses using reminiscence with their patients can assist in trust building and learn about African American health beliefs and practices. Transcultural nurse researchers incorporating CBPR methods while keeping in mind the strengths of the African American oral traditions can assist with overcoming the barriers of mistrust and recruitment and retention associated with depression research in this population.

Declaration of Conflicting Interests

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