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Special Section: Reminiscence through a Cultural Lens

Development of a Culturally Tailored Peer-led Reminiscence Intervention To Decrease Depressive Symptoms in Older Black Adults

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The purpose of this study was to obtain data that would inform the development of a Reminiscence Resource Guide directed at preparing facilitators in a culturally tailored peer-led reminiscence intervention to decrease depressive symptoms among a sample of older Black adults. Focus group methodology was used to obtain culturally appropriate learning styles among the participants and their acceptance of a peer-led reminiscence intervention. The mean age of the sample was 73.8 (SD=10.0), the majority of participants were female (75%). Under the supervision of the second author, the focus groups were led by a Black graduate student who had been trained in focus group techniques. Data were collected until saturation was reached. Sessions were taped and transcribed verbatim. Borkan's immersion/crystallization techniques were used to analyze the data. The following themes related to learning styles and acceptance of the peer reminiscence process emerged; (a) we can learn from one another, (b) preference for experiential learning, (c) create a trusting, social environment and (d) unexpected reminiscences. From these data, the Reminiscence Resource Guide was developed and evaluated by the community members. Future directions include implementing the training program and testing the peer-led intervention in a randomized controlled trial.

Keywords: Cultural Tailoring, Peer-led Reminiscence, Older Black adults, Community-based Participatory Research

Depression is the leading cause of disability in the United States; however, many people with depression never receive treatment (NIMH, 2007). Untreated, minor and moderate depressive symptoms can progress to major depressive disorder, poorer health outcomes, and a higher risk of suicide (Conwell, 2006; Grabovich, Lu, Tang, Tu & Lyness, 2010). Studies examining the impact of depression on health care costs found that depressed older adults have significantly higher health care costs than non-depressed older adults regardless of chronic morbidity (Katin, Lin, Russo, & Unitzer, 2003). Meeks, Vahia, Lavretsky, Kulkarni, and Jeste (2011) found that sub-threshold depression (a) is two to three times more prevalent than major depression in older adults, (b) negatively impacts their quality of life, and (c) increases healthcare utilization and costs, risk of dementia, and suicidal ideation.

According to the Institute of Medicine (2012), older Black adults are one of the fastest growing minority groups and are at risk for depressive symptoms because of their high rates of hypertension, diabetes, and heart disease. In addition, older Black adults suffer more psychological distress than other racial groups. The sources of this distress can be traced to lifelong exposure to racism and discrimination, and the socio-economic consequences of slavery and sharecropping. In a meta-analysis of perceived racism and mental health among Blacks, results showed that the greater the exposure to racism, the greater the probability of psychological distress (Pierterse, Todd, Neville, & Carter, 2012). Despite the high number of risk factors for depression, older Black adults with depressive symptoms continue to be underdiagnosed and undertreated (Williams, Gonzalez, & Neighbors, 2007). Serious dis-parities exist in the utilization of mental health care by

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older Black adults. When compared to other racial groups, older Black adults are less likely to be identified as depressed by their primary health care providers, and often delay seeking treatment until their symptoms are severe (McGuire & Miranda, 2008). Older Black adults face many barriers to mental healthcare utilization for depression care, including lack of awareness or distrust of mental healthcare services, the stigma associated with depression, the inability to afford services, and the culturally rooted conviction that mental health problems can be managed through other coping strategies such as praying.

Several programs developed for depression management have been tested. However, gaps still persist in the care of depressive symptoms and prevention of major depression in Black adults. For example, important work has been done on depression interventions for Black adults, in particular IMPACT (Unützer et al., 2002) and PROSPECT (Sriwattanakomen, 2010), that utilize collaborative care models in primary care. However, the focus of these models is on treatment of major depression, not on decreasing depressive symptoms, minor depression or prevention. In addition, in a meta-analysis, Thota et al., (2012) noted that although collaborative care models for depression treatment demonstrated clinically meaningful improvement, many barriers to implementation were found. For example, patients showed a reluctance to enroll, failed to keep appointments, and lacked organizational commitment. In addition, staff experienced difficulties reaching patients in the community. Thus, there is a call for models of depression care that focus on access and culturally tailored interventions for minority populations.

The Peer Reminiscence Intervention for Minority Elders (PRIME) is an example of a culturally tailored model that utilizes the oral traditions of older Black adults as well as their informal support networks to mitigate barriers associated with underutilization of mental health services. The result of these effects is a decrease in depressive symptoms and the prevention of major depression. In PRIME, older Black adults are trained to facilitate integrative reminiscence with their peers, create a support network that will raise community awareness of depressive symptoms, and provide a pathway to mental health services in the community.

Reminiscence, in the present study, is defined as interpersonal and integrative (Watt & Wong, 1991) as older Black adults are encouraged to reflect on past accomplishments, failures, and other experiences while the peer reminiscence facilitator probes and validates these experiences through active listening. The purpose of this paper is to describe the development of the Reminiscence Resource Guide. The guide contains material for the 12-week training program for the peer reminiscer facilitators and structure for the delivery of the reminiscence intervention. For the purpose of this study and consistent with the National Institutes of Health (2001), the term Black used in this paper includes individuals of African, African-American, and African Caribbean descent.

Reminiscence

There is increasing evidence that reminiscence and life review interventions are effective in alleviating depressive symptoms and improving well-being in older adults (Bohlmeijer, Kramer, Smit, Onrust, & van Marwijk, 2009; Bohlmeijer, Roemer, Smit & Cuijpers, 2007). However, reminiscence research with Black adults has been mostly descriptive in nature with few intervention studies found in the literature. For example, Merriam (1993) in a descriptive study of older Black and White adults (N=291) reported that Blacks reminisce more than Whites for the purposes of understanding themselves and for teaching about the past. Washington (2009) and Shellman (2011) conducted work with older Black samples to test the feasibility of the Reminiscence Functions Scale developed by Webster (1993; 1997) with Black samples. Findings from this work demonstrated that participants had difficulties reading and understanding the scale. Subsequently, Washington modified and tested the Reminiscence Functions Scale (2009) with a racially diverse sample (N=271). Using principal component analysis with varimax rotation, a 39-item, seven factor scale was retained. Results demonstrated that in contrast to Webster's eight factor Reminiscence Functions Scale, the self-identity and problem solving factors clustered together, the factors were combined and renamed self-regard which accounted for 30% of the variance (Washington, 2009).

Shellman and Zhang (2014) confirmed the seven-factor scale in a sample of Black adults (N=335). In a secondary data analyses of these data, Shellman (2016) examined age and gender differences in reminiscence functions in Black adults (N=335). A 2 (gender) by 7 (age) between-subjects MANOVA was conducted with seven reminiscence factors (Conversation, Bitterness Revival, Intimacy Maintenance, Boredom Reduction, Self-regard, Death Preparation, and Teach and Inform) as the dependent variables. Wilk's Lambda showed a significant overall effect for both age F (42, 148) = 1.4, p = .01 and gender F (7, 315) = 2.7, p = .01. Age groups >70 scored highest on the Teach/ Inform function. In this sample, males reminisced more for Bitterness Revival while women reminisced more frequently to Teach/Inform and for Intimacy Maintenance.

In a contextual examination of reminiscence functions in older Black adults using focus group methods, Shellman, Ennis, & Bailey-Addison (2011) found differences in why older Black adults reminisce when compared to Webster's taxonomy of reminiscence functions. Results showed that older Black adults perceived reminiscing to prepare for one's death as more negative and that reminiscing to keep close to the memories of a loved one who has passed away was perceived as more positive when compared to other ethnic groups. In one of the few intervention studies involving Black adults found in the literature, Sabir, Henderson, Kang, and Pillemer (2016), conducted a two-group

randomized control intervention study to test an eight-week Attachment Focused Integrative Reminiscence Intervention (AFIR). The findings from this study indicated that AFIR had a positive impact on depression, perceived stress, and emergency room visits in the sample of older African-Americans (N=56).

As an initial step in the long-term goal of our reminiscence research program to decrease depressive symptoms and prevent major depression, we pilot tested the effects of integrative reminiscence, delivered by a professional Black nurse, on depression symptoms in a sample of older Black adults. Utilizing a three-group pre-test post-test experimental study we showed that, after adjusting for pre-intervention CES-D scores, there were significant differences between groups $F(2,52) = 8.6$, $p = .001$. In the group comparisons, Holms Correction Method identified that the CES-D mean score in the reminiscence group ($M = 6.8$, $SD = 4.7$) was significantly lower than the control ($M = 14.6$, $SD = 10.1$) and health education groups ($M = 11.7$, $SD = 7.1$) (Shellman, Mokel & Hewitt, 2009). However, our experiences with issues of mistrust of research and researchers, and resistance to participation in mental health studies (Shellman & Mokel, 2007; 2010) led us to conclude that a community-based, culturally tailored peer reminiscence intervention (PRIME) will best address the mental health disparities that exist for older Black adults.

The PRIME Model

The PRIME Model provides the conceptual structure for our program of reminiscence research. Major concepts of this model include cognitive reconstruction, cultural tailoring, and peer-led interventions. See Figure 1.

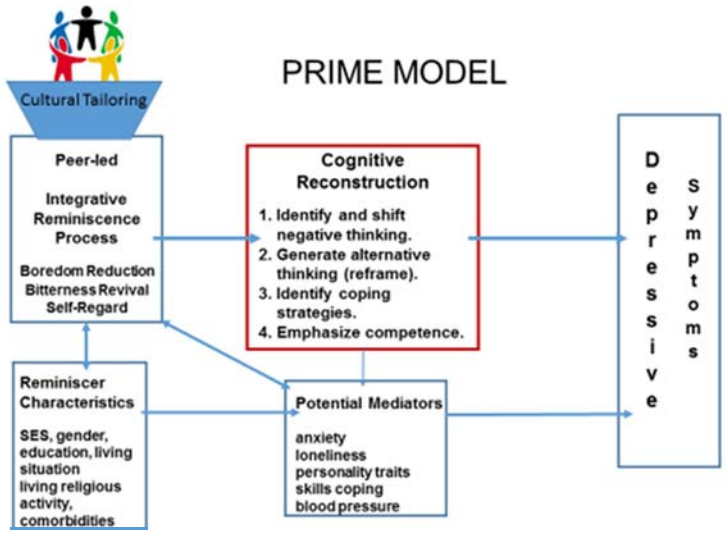

Figure 1. The PRIME model

Cognitive Reconstruction

According to the theory of cognitive adaptation proposed by O'Rourke (2002), the way people interpret their interpersonal relations and life histories is significantly associated with wellness in later life. The key construct of the theory is "cognitive reconstruction." Individuals are helped to think differently about a phenomenon. Through integrative reminiscence there is reconstruction of negative thoughts, attitudes, and beliefs. The strategies that promote integrative reminiscence as an intervention to decrease depressive symptoms are: (a) identifying and shifting depressogenic thinking, (b) generating alternative thinking about the past (reframing thinking), (c) identifying coping strategies, and (d) emphasizing competence (Cappeliez, 2007). These strategies, according to Cappeliez (2006), result in cognitive reconstruction of the older adult and allow for new ways of thinking about their lives. There has been a strong link between integrative reminiscence and physical and mental well-being (Cappeliez & O'Rourke, 2006; O'Rourke, Cappeliez, & Claxton, 2011). Integrative reminiscence has been shown to decrease depressive symptoms in older adults (Bohlmeijer, Kramer, Smit, Onrust, & van Marwijk, 2009) and older Black adults (Shellman et al., 2009). A meta-analysis that examined the effects of behavioral interventions on depressed older adults found that effect sizes were stronger for reminiscence than for active control groups, psycho-education, physical exercise, psychodynamic therapy, and other supportive interventions (Pinquart et al., 2007). PRIME builds upon our pilot work with reminiscence and community-based participatory research but adds the significant innovation of peer reminiscence facilitators to deliver the intervention.

Cultural Tailoring

Cultural tailoring is an important component of our model. It is evident from the literature that using traditional mental health services to treat culturally diverse communities has not worked well (Smith, 2011). Cultural tailoring refers to matching intervention goals with the needs and sensitivities of the specific population. It uses feedback from the community to help develop an intervention that engages participants in ways that draw upon their cultural orientation in the context of their daily lives. The PRIME research team, aware of the strong oral traditions within the Black community (Stewart, 1997), tailored the intervention to capitalize on this cultural marker. One of the important coping mechanisms during the times of slavery was to build on the oral traditions of their native country in sharing stories and singing in religious rituals. This oral tradition has been passed on to

later generations and continues to evolve today. While this is an important point, we are sensitive to intracultural diversity that exists within any cultural group and recognize that it is important to guard against stereotyping.

A meta-analysis conducted by Smith et al. (2011) found that culturally-tailored mental health treatments were more effective than traditional treatments (d = .46). In addition, mental health services targeted to a specific cultural group were several times more successful than services provided to participants from a variety of cultural groups. In a comprehensive systematic review of the literature to identify interventions that eliminate disparities in depressive disorder outcomes between non-Hispanic whites and ethnic minorities, it was noted that socio-culturally-tailored prevention interventions are more effective than standard depression treatment programs (Van Voorhees, Walters, Prochaska, & Pfeiffer & Quinn, 2007).

Peer-delivered Interventions

Older Black adults are more likely to use informal support networks (family members and trusted peers) than professional services for mental health care (Woodward, 2008). Peer interventions have been shown to be effective approaches with Blacks in diabetes management (Samuel-Hodge et al., 2006), weight loss (Kennedy et al., 2005), and increased prostate cancer screening (Weinrich et al., 1998). In a meta-analysis examining the efficacy of peer support interventions for depression, Pfeiffer, Heisler, Piette, Rogers, & Valenstein (2011) found that peer support interventions decrease depressive symptoms more than usual care. Results from this study indicate a need for additional peer intervention research with more diverse populations and clinical trials to determine optimal dose and approaches to providing support. We found no studies that used peer-led reminiscence interventions to decrease depressive symptoms.

Our work leading up to this study was informed by qualitative and quantitative reminiscence research studies conducted by the PI and stakeholders over the past seven years. As a key step in the development of the PRIME intervention, the community, in partnership with the PRIME research team, worked collectively to develop a Reminiscence Resource Guide to facilitate the peer-led reminiscence intervention. The aims that guided this project were as follows:

1. Develop a culturally-tailored Reminiscence Resource Guide.

2. Evaluate the Reminiscence Resource Guide for content and cultural sensitivity using community-based participatory research methods.

Method

Focus group methodology was used in this descriptive study to gather data for the development and evaluation of the Reminiscence Resource Guide.

Setting

The senior center, located in an urban setting in the Northeast U.S., has a membership of over 700 Black adults, aged 55 and older. The majority of participants come from a blue-collar working class population with an average of 10.2 years of education (Shellman, 2010). Forty-one percent of the population reports they were born in the Southern U.S. and maintain links with family and friends, and 60% are female. The center provides a range of services such as daily lunch, hairdressing services, health services, and opportunities for field trips. It is located in a mostly Black urban community near a large health care facility that provides outpatient services to underserved populations

Participants

All members of the senior center who were at least 55 years old, Black, English speaking, and willing to talk about their views on the development of PRIME were eligible to participate in this study. Thirty-four older Black adults were recruited for the study. Twenty percent of the focus group participants were male, eighty-nine percent were born in the United States, and ten percent reported they were born in the Caribbean. The average age of the sample was 73.8 (SD=10.0).

Procedures

University IRB approval was obtained before the study began. Recruitment of Black participants for research studies is challenging because of their mistrust of the research process (Jones, Steeves, & Williams, 2009; Shellman & Mokel 2010). Several considerations were made to recruit participants into this study. For example, the research team, which includes Black undergraduate and graduate nursing students, is continually present at the center to maintain our relationship with the seniors. The students conduct health activities and serve as research assistants in our studies. In addition, to prevent any issues of mistrust or misinformation, the team developed a recruitment script that outlined the details of the project. A Black graduate research assistant who had developed a relationship with the senior center members made a general announcement in the common area and informed the members that recruitment would begin over the next several weeks. The senior center nurse, a longstanding trusted member of the center and research team, was also instrumental in individually discussing the benefits of the study to members.

PRIME Reminiscence Resource Guide

The purpose of the resource guide is to provide educational materials and resources to train older Black adults to facilitate reminiscence with their peers. The guide was organized using the Peer Support Resource Manual (2001) developed by the British Columbia Ministry of Health Adult Mental Health Policy Division as a guide. The reminiscence content was developed using the following; (a) Handbook of Structured Life Review (Haight & Haight, 2007), (b) the research team's previous reminiscence work with older Black adults including focus group sessions geared toward understanding the cultural perception of depression (Shellman, Ennis, & Addison, 2011; Shellman, & Mokel, 2010; Shellman, Mokel, & Hewitt, 2009) and (c) the first author's experience of teaching reminiscence to students and health professionals. For example, using these materials, the first author developed the 4-R Process (Relate-Reflect-Restate-Respect) to teach the older Black adults how to facilitate integrative reminiscence with their peers. The guide also includes; (a) content on the process of conducting integrative reminiscence, (b) tips for communication with peers, (c) confidentiality, (d) signs and symptoms of depression (e) referral resources, and (f) evaluation surveys. Particular attention was given to identifying potentially problematic responses during reminiscence sessions such as talking about suicide. We developed a protocol to guide the Peer Reminiscence Facilitators (PRFs) when and how to seek the assistance from the senior center nurse and senior center director, a licensed social worker.

The research team created a draft of the guide taking into consideration readability, font size, vocabulary, and language (Ridpath, Greene, & Wiese, 2009). Efforts were made to use language and beliefs familiar to this population, as evidenced by previous studies conducted with the seniors. For example, "feeling blue, lonely, or stressed out" were terms used in place of depression because these were words that many of the seniors often used (Shellman, Mokel & Wright, 2007). The senior center director, a key stakeholder in this project, reviewed the manual and provided feedback before the focus groups began.

Data Collection Process

Data were obtained utilizing focus groups which were held in a private room in the senior center. The audio-taped sessions lasted 45-60 minutes**.** Moderator guides were developed to structure the focus group sessions and ensure consistency of data collection. Two phases of focus groups with members of the senior center were held to develop the reminiscence resource guide. In Phase One, five focus groups (N=34) with five to seven participants each were conducted to collect data on the following; (a) participants' views of the overall presentation and wording of the resource guide, (b) appraisals of the actual peer reminiscence process, and (c) feedback on learning styles and preferences. Questions that guided the focus groups are presented in Appendix A.

These data were utilized to revise and further develop the reminiscence resource guide. During Phase Two, participants from the first phase of focus groups were reconvened and asked to respond to the latest draft regarding the following: (a) overall presentation of the revised resource guide with respect to formatting and understandability, (b) cultural acceptability of the content, and (c) feasibility and usefulness. The moderator's guide for Phase Two focus groups are displayed in Appendix B. Data saturation was reached after three focus groups of five to six participants were conducted.

Data Analysis

The contextual data were professionally transcribed and then organized using QSR International's NVivo 9, a qualitative data analysis software program. The data were analyzed using an immersion-crystallization approach as described by Borkan (1999). The immersion and crystallization aspects of this technique were conducted by the research team. The two researchers independently immersed themselves into and experienced the data by (a) reviewing the transcripts for each focus group, (b) listening to the audiotape to enhance the written word for nuance and tone, and (c) examining moderator notes for any thoughts that emerged during the focus groups. Crystallization occurred during the reading and rereading of transcripts when the researchers reflected on the immersion experience and searched for meaningful segments of information related to (a) learning styles and preferences, (b) the cultural sensitivity and acceptability of the content and presentation of the Reminiscence Resource Guide, (c) the reminiscence training process. The researchers came together to discuss their independent findings and established categories through discussion and agreement. Categories were developed based on the frequency, intensity, and consistency of meaningful segments. From the meaningful segments, common themes or exemplars were developed. Finally, another member of the research team not involved in the analysis process reviewed the results with participants via the final version of the Reminiscence Resource Guide to ensure the accuracy of the results.

Results

Phase 1 Focus Groups

The results from the first phase of focus groups elicited the following themes: (a) we can learn from one another, (b) experiential learning, (c) create a trusting, social environment, and d) unexpected reminiscences.

We Can Learn From One Another

Overall, participants stated that sharing memories with peers would be a positive experience. They felt that peers would be most able to relate to each other's stories and expressed the opinion that discussing personal issues with each other would help them learn about coping and making choices. As one participant stated about the focus groups, *"I enjoy it. I learn. I've learned some things just sitting here."* On more than one occasion, participants voiced a need for older adults to get together and share their memories:

> *"This is why I like this kind of thing because it starts people to really saying, you know, I, I do have something to offer because each one of us has something that we can offer to one another to make it, like make life more pleasant for one another*."

Experiential Learning

Participants overwhelmingly wanted bright, warm colors for the manual and more graphics than words because many, as one participant stated, "we're not really readers" or could not read at all. Some even suggested creating an audio CD to accompany the resource guide which would address any problems with reading and that the manual have simple language and consist of words they normally use such as "not feeling so fine" for depression. As one participant concluded, *"I've been Black all my life. Black folks don't get depressed."* The participants were clear about their preference for learning by watching someone and then trying it for themselves. For example, one participant stated, "*I would rather see it and then do it myself*," while another stated, *"I'm more a visual learner. I always look at things first, and then I read it. So, I do things kind of backwards."* These comments were strongly supported with multiple affirmations from the group.

Create a Trusting and Social Environment

Despite a willingness to reminisce with peers, participants emphasized that a peer reminiscence facilitator would need to be trustworthy. Many reported concern about confidentiality and that a peer facilitator has to be "*somebody who isn't going to tell all your business once you talk to that person. They ain't go out and repeat what you said.*" Furthermore, unless the peer facilitator was supportive and knowledgeable, participants would be inclined to be selective about what they shared.

Unexpected Reminiscences

One important goal for the team was to identify reminiscence topics that the participants like to reminisce about to foster more positive thinking. During this part of the discussion participants shared topics they normally reminisced about with peers and when alone. Participants reported that reminiscence involved thinking about all kinds of events and that it occurred frequently in their lives. Happy memories were often about the simple and satisfying lives they once had as youngsters, often reported as country life in the South surrounded by large families. They seemed most fond of the simple and flavorful foods they once ate, the closeness they had with older relatives, especially grandparents, and the lessons they drew from being in that environment. Examples of old time fun as young adults, which included the dances they attended, the fashions they enjoyed, and the music they played, invariably prompted laughter and more spontaneous reminiscence among the groups.

Although we did not specifically ask for negative kinds of reminiscences, stories related to loneliness, burdens such as failing health, and feeling bad emerged during the focus group sessions. There were other participants that reported they found little opportunity to reminisce with others either because they lacked someone to confide in or because they had grown accustomed to handling their problems on their own. Some felt that their families were more dependent on them for practical help than for the pleasantries of sharing memories and found those relationships to be stressful and burdensome. In addition, some found that reminiscence was painful because their lives had changed so much from what they once were. The majority of participants struggled with the emotional effects of the death of loved ones, the profound changes in society, social isolation, and failing health. Some revealed their struggles with depression and their fear of going into what the participants called a valley. For example, one participant shared that he went to bed feeling bad (and) he was disappointed that he woke up the next morning because now he's looking forward to the same thing he had yesterday. During this and similar moments, participants were found to offer consolation to one another and solutions for coping with sadness and despair. Participants frequently said that feeling depressed was a condition that participants avoided, and if they were ever in that state, they struggled through it alone.

Phase 2 Focus Groups

Once data were collected, transcribed and analyzed, the original draft of the Reminiscence Resource Guide (RRG) was revised by the research team. For example, the team worked to (a) incorporate culturally appropriate wording for depression, (b) add graphics, (c) develop an oath of confidentiality for the facilitators and reminiscers, (d) create culturally appropriate reminiscence scripts, and (e) review wording for ease of understanding and readability.

The participants from the first focus groups were reconvened and asked to review the revised RRG. The focus group leaders reported that the participants were excited to see the final product. Each of the members were given a draft to review and asked to comment on the presentation, cultural sensitivity, and the feasibility of using the guide to train peers. (see Appendix B). The

participants were very impressed and grateful that the RRG was adapted to include all of their suggestions. They expressed a sense of pride about the RRG and felt respected, as one participant stated in a seemingly surprised voice, "*you did what we said*." The focus group members commented that they liked the size of the text and thought that the color and pictures were adequate. They especially liked the table of contents and pages to take notes while facilitating an integrative reminiscence session.

The group gave positive feedback on the reminiscence process developed by the PI as the four R's, Relate, Reflect, Restate, and Respect. Many in the group commented on the importance of Respect and Relate as key steps in conducting reminiscence. One interesting finding was their perception that the peer reminiscence facilitator be an authority figure. This gave us insight into the need to clarify the role of the facilitator as a listener and supporter. The focus group leaders took the opportunity to discuss the facilitator role during the focus group and the research team clarified the definition of a peer reminiscence facilitator in the Reminiscence Resource Guide.

Discussion and Future Directions

While conducting the focus groups it was clear that an opportunity for older adults to reminisce with peers has the potential to be a positive, health promoting experience. Participants were found to easily share personal and painful issues such as depressive symptoms and despite their stated reluctance to discuss their problems with anyone, seemed to genuinely enjoy the structured and personal nature of the focus groups. Even those who were initially reserved found opportunities to contribute to the discussions and to readjust their thoughts to identify their strengths and positive coping processes. As they engaged in discussion, participants found that they shared a common upbringing that involved living simply and utilizing their available resources. Together with family and strong role models, they shared that they were self-reliant and healthy which was something they found lacking in society today. The support the participants provided to one another during the sharing of more painful issues was noteworthy and supported the use of a peer led reminiscence intervention with older Black adults. These data also reinforce the need for a program of integrative reminiscence that allows Black older adults to reminisce using a guided process to reframe thinking from a negative to a more positive perspective as we discovered in our previous work to decrease depressive symptoms among older Black adults.

The data gathered from the focus groups revealed insights into the learning styles, cultural preferences, and the feasibility of training older Black adults to facilitate integrative reminiscence. As a result of their participation in this process, we discovered how to (a) frame the reminiscence training program to best meet their learning needs, (b) discuss sensitive topics such as depression and religion in a culturally appropriate way, and (c) develop a culturally tailored Reminiscence Resource Guide which is presently being used to train a group of peer facilitators (the table of contents is presented in Appendix C). Based on the work of Israel, Schulz, & Parker (2005), and Rodriguez, Baumann, & Schwartz (2010) the Peer Reminiscence Resource Guide is considered a "living document." Adaptations can be made during its development and throughout the training of the Peer Reminiscence Facilitators to ensure cultural tailoring of PRIME so that it meets the mental health needs of the older Black community.

In response to the participants' request for experiential learning, funding was sought and secured to develop video vignettes to demonstrate different types of reminiscers (negative, depressed, normal) and what a peer reminiscence facilitator should do in each case. This training is currently being conducted at the center. Following the training experience, we will review the guide and make any appropriate changes as necessary so the RRG can be used as a model for other programs. Future directions include pilot testing the PRIME intervention with an experimental design. Based on these results, funding will be sought to conduct a multiple site randomized control trial.

At this point, it is important to note that this work is an example of a community-based participatory approach to research that has yielded opportunities for ongoing research with gatekeepers, seniors, and students. This can be a challenging process that requires a long-term commitment to a community that includes respect, sensitivity and understanding of the culture. We, at the University of Connecticut School of Nursing, are indebted to this community for their openness, acceptance, and participation in our work.

References

Bohlmeijer, E., Smit, F., Cuijpers, P. (2003). Effects of reminiscence and life review on late-life depression: A meta-analysis. *International Journal of Geriatric Psychiatry,* 18 (12), 1088-1094.

Bohlmeijer, E., Kramer J, Smit F, Onrust S, & van Marwijk H. (2009). The effects of integrative reminiscence on depressive symptomatology and mastery of older adults. *Community Mental Health Journal, 45*(6):476-84. doi: 10.1007/s10597-009-9246-z.

Bohlmeijer,E., Roemer, M., Cuipers, P., & Smit, F. (2007). The effects of reminiscence on psychological well-being in older adults: A meta-analysis. *Aging and Mental Health*, 11(3), 291-300.

Borkan, J. (1999). Immersion/crystallization. In B. Crabtree & W. Miller (Eds.), *Doing qualitative research* (2nd ed.) (pp. 179-194). Thousand Oaks, CA: Sage.

Cappeliez, P., & O'Rourke, N. (2006). Empirical validation of a model of reminiscence and health and later life. *Journal of Gerontological Sciences: Social Sciences, 61*(4), 237-244.

Cappeliez, P. (2007, November). *Integrating cognitive and narrative approaches in reminiscence interventions for depressed older adults*. Poster session presented at the 7th Biennial International Reminiscence and Life Review Conference, San Francisco, CA.

Conwell Y. (2004). Suicide. In S. P. Roose & H. A. Sackeim (Eds.). *Late-life depression*. Oxford, UK: Oxford University Press. pp. 95–106.

Grabovich, A., Lu, N., Tang, W., Tu, X., & Lyness, J. M. (2010). Outcomes of subsyndromal depression in older primary care patients. *American Journal of Geriatric Psychiatry*, 18, 227–235. doi:10.1097/JGP.0b0 13e3181cb87d6

Haight, B. K., & Haight, B. (2007). *The handbook of the structured life review*. Baltimore: Health Professions Press.

Institute of Medicine (2012). *Living well with chronic illness: A call for public health action*. Washington (DC): The National Academies Press.

Israel, B., Eng, E., Schulz, A., & Parker, E. (2005). Introduction to methods in community-based participatory research for health. In Israel, B., Eng, E., Schulz, A., & Parker, E. (Eds.), *Methods of community-based participatory research for health* (pp. 3-26). San Francisco, CA; Jossey-Bass.Jones,

Jones, R. A., Steeves, R. & Williams, I. (2009). Strategies for recruiting African American men into prostate cancer screening studies. *Nursing Research, 58*(6), 452-456.

Katon, W., Lin., E., Russo, J., & Unutzer, J. (2003). Increased medical costs of a population-based sample of depressed elderly patients. *Archives in General Psychiatry, 60*, 897-903.

Kennedy, B. M., Paeratakul, S., Champagne, C. M., Ryan, D. H., Harsha, D. W., McGee, B., Johnson, G., Deyhim, F., Forsythe, W., & Bogle, M. L. (1998). A pilot church-based weight loss program for African-American adults using church members as health educator: A comparison of individual and group intervention. *Ethnicity and Disease*, 15(3), 373-378.

Kreuter, M. W., Lukwago, S. N., Bucholtz, D. C., Clark, E. M., & Sanders-Thompson, V. (2003) Achieving cultural appropriateness in health promotion programs: Targeted and tailored approaches. *Health Education and Behavior*, 30, 133–146. doi: 10.1016/j.ypmed.2004 .10.013

McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: Policy implications. *Health Affairs, 27*, 393-403.

Merriam, S. (1993). Race, sex, and age-group differences in frequency and uses of reminiscence. *Activities, Adaptation and Aging, 18*, 1–18

Meeks, T. W., Vahia I. V., Lavretsky, H., Kulkarni, G., & Jeste, D. V. (2011). A tune in "a minor" can "b major": A review of epidemiology, illness course, and public health implications of subthreshold depression in older adults, *Journal of Affective Disorders, 129*, 126-142.

National Institute of Mental Health (NIMH). (2007). *Older adults: Depression and suicide facts.* Retrieved from http://www.nimh.nih. Gov/health/publications/older-adults-depression-and-suicide-facts-fact-sheet/index.shtml.

NVivo qualitative data analysis software; QSR International Pty Ltd. Version 9, 2010.

O'Rourke, N. (2002). A social cognitive model of well-being among older adults. *Constructivism in the Human Sciences, 7*, 65-80.

O'Rourke, N., Cappeliez, P., & Claxton, A. (2011). Functions of reminiscence and the psychological well-being of young-old and older adults over time. *Aging and Mental Health, 15*, 271-281.

Pfeiffer, P., Heisler, M., Piette, J., Rogers, M., & Valenstein, M. (2011). Efficacy of peer support interventions for depression: A meta-analysis. *General Hospital Psychiatry, 33*, 29-36.

Pietrerse, A., Todd, N., Neville, H., Carter, R. (2012). Perceived racism and mental health among Black American adults: A meta-analytic review. *Journal of Counseling Psychology, 59*, 1-9. doi: 10.1037/a002 6208.

Ridpath, J. R., Greene, S. M., & Wiese, C. J. (2009); *PRISM Readability Toolkit*. 3rd ed. Seattle: Group Health Research Institute.

Rodriguez, M., Baumann, A., & Schwartz, A. (2010). Cultural adaptation of an evidenced based intervention from theory to practice in a Latino community context. *American Journal of Community Psychology, 47*, 170-186.

Sabir, M., Henderson, C., Kang, S., & Pillemer, K. (2016. Attachment-focused integrative reminiscence with older African-Americans: A randomized controlled intervention study, *Aging and Mental Health, 20*(5), 517-528. doi: 10.1080/13607863.2015.1023764.

Samuel-Hodge, C. D., Keyserling, T. C., France, R., Ingram, A. F., Johnston, L. F., Pullen Davis, L., Davis, G., & Cole, A. S. (2006). A church-based diabetes self-management education program for African-Americans with type 2 diabetes. *Preventing Chronic Disease, 3*(3), A93.

Shellman, J. (2016). Examination patterns and functionns of reminiscence in a sample of Black adults; Implications for psychiatric nursing. *Archives in Psychiatric Nursing. 30*, (2016), pp. 387-392 DOI: 10.1016/j.apnu.2016.01.006.

Shellman, J., Mokel, M., & Wright, B. (2007). "Keeping the bully out": Understanding older African Americans' beliefs and attitudes toward depression. *Journal of the American Psychiatric Nurses Association, 13*, 230-236.

Shellman, J., Mokel, M, & Hewitt, N. (2009). The effects of integrative reminiscence on depressive symptoms in older African Americans. *Western Journal of Nursing Research, 31*(6), 772-86.

Shellman J., Ennis, E., & Addison, K. (2011). A contextual examination of reminiscence in older African-Americans. *Journal of Aging Studies, 25*(4), 348-354.

Shellman, J., & Mokel, M. (2010). Overcoming barriers to conducting an intervention study for depression in an older African-American population. *Journal of Transcultural Nursing, 21*(4), 361-9.

Shellman, J., & DiLeone, C. (2015, November). *Development of a peer reminiscence intervention for minority elders*. Poster presented at the 11th Biennial International Reminiscence and Life Review Conference, Orlando, FL.

Shellman, J., & Zhang, D. (2014). Psychometric testing of the modified reminiscence functions scale. *Journal of Nursing Measurement, 22*(3), 500-510.

Smith, T., Rodriguez, M., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology, 67*(2), 166-175.

Sriwattanakomen, R., McPherron, J., Chatman, J., Morse, J., Martire, L., Karp, J., Houck, P., Bensasi, S., Houle, J., Stack, J., Woods, M., Block, B., Thomas, S., Quinn, S., & Reynolds, C. (2010). A comparison of the frequencies of risk factors for depression in older Black and White participants in a study of indicated prevention. *International Psychogeriatrics, 22*(8), 1240-1247.

Stacciarini, J. M., Shattell, M. M., Coady, M., Wiens, B. (2010). Review: Community-based participatory research approach to address mental health in minority populations. *Community Mental Health Journal, 47*(5), 489-97. DOI:10.1007/s10597-010-9319-z.

Stewart, C. (1997). Soul survivors: An African American spirituality. Louisville, KY: Westminster John Knox Press.

Thota, A., Sipe, T., Byard G., Zometa, C., Hahn, R., McKnight-Eily, L., Chapman, D. P., Abraido-Lanza, A. F., Pearson, J, L., Anderson, C. W., Gelenberg, A. J., Hennessy, K. D., Duffy, F. F., Vernon-Smiley, M. E., Nease, D. E., & Williams, S. P., (2012) Collaborative care to improve the management of depressive disorders: A community guide systematic review and meta-analysis. *American Journal of Preventive Medicine*, 42, 525–538. DOI: 10.1016/j.amepre.2012.01.019.

Unützer, J., Ka, L, Hoffing, M., Della Penna, R.D., Noël P.H, Lin, E.H, Areán, P.A., Hegel, M.T., Tang, L, Belin, T.R., Oishi, S, Langston, C. (2002) IMPACT Investigators: Improving mood-promoting access to collaborative treatment. *Journal of the American Medical Association, 288*(22), 2836-2845.

Van Voorhees, B., Walters, A., Prochaska, & Quinn, M. (2007). Reducing health disparities in depressive disorders outcomes between non-Hispanic Whites and ethnic minorities: A call for pragmatic strategies over the life course. *Medical Care Research and Review, 64*, 157S-162.

Washington, G. (2009). Modification and psychometric testing of the modified reminiscence functions scale. *Journal of Nursing Measurement, 17*(2), 134−147.

Watt, L., & Wong, P. T. (1991). A taxonomy of reminiscence and therapeutic implications. *Journal of Mental Health Counseling, 12*, 270−278.

Webster, J. (1993). Construction and validation of the reminiscence function scale. *Journal of Gerontology, 48*, 256-262.

Webster, J. (1997). The reminiscence function scale: A replication. *International Journal of Aging and Human Development, 44*, 137-148.

Williams D.R., Gonzalez H.M., Neighbors, H. (2007). Prevalence and distribution of major depressive disorder in African Americans, Caribbean blacks, and non-Hispanic Whites: Results from the National Survey of American Life. *Archives of General Psychiatry*, 64, 305–315.

Appendix A

Focus Group 1 Moderator Guide

Phase	Topics/ Questions
1. Preamble	1. Introduction of moderator and note taker. 2. Focus group etiquette and confidentiality 3. Purpose of the focus group
2. Introduction and Ice Breaker	1. Introduction of members. 2. Tell us how often you find yourself reminiscing or sharing memories with someone else. What do you like to reminisce about?
1. Main Body of Discussion	A. Resource Guide – presentation, language and wording 1. When you are reading health information, how do you like the material to look? What makes the information easier to understand? 2. What kinds of things draw your attention when reading health information that you want to learn? 3. What kinds of things do you dislike when you are presented with health information? 4. Show samples of draft to participants (letter size, color etc.) for feedback. 5. Tell me, how you would express that you're feeling good? What about when you're feeling down or even depressed? How do you describe feeling stressed out? B. Training acceptability and feasibility 1. Which way do you use to learn new things: by reading about the material, by watching the material on a video, by listening to someone, by doing a task, or do you like to use all four ways to learn new material? 2. What should we know about how you feel about reminiscing with peers? 3. How willing are you to share your memories with your peers? 4. What problems do you see that people might have in sharing their memories with someone from the senior center? C. Reminiscence Resource Guide – content areas 1. When you are feeling "down" (use words they've used), what helps you cope or feel better? What kinds of memories do you reminisce about with peers? 2. What kinds of memories make you feel better? 3. When you have had a friend who was "sad" (use the words they've used), what kinds of things did you find most useful to talk about to make them feel better? 4. What memories do you think are best to share with one another?
4. Closure	A. Inform participants that the focus group session is about to end B. Summarize the main points made and highlight any potential differences brought up during the focus group. Final questions: 1. What is the most important thing you feel I should know about this resource guide? 2. What final thoughts do you have that you feel I haven't mentioned?

Appendix B

Reminiscence Resource Guide Table of Contents

Phase	Topics/ Questions
1. Preamble	1. Introduction of moderator and note taker. 2. Focus group etiquette and confidentiality 3. Purpose of the focus group—provide copies of the resource guide to participants to review content.
2. Introduction	1. Please tell us if you've ever used a training or resource guide before that has helped you with learning a new skill. 2. Based upon what is said, I think this is a good start to get us thinking about the Reminiscence Resource Guide that we will be looking at today. 3. Ask participants to underline or circle any words or phrases that they believe are not commonly used among your peers or that they have difficulty understanding while we are reviewing the resource guide.
4. Main Body of Discussion	A. Overall presentation/format 1. Since this resource guide will be used to train peers over the age of 55, we want to make sure that the resource guide flows well and is not too difficult to work with. So, tell me what you think about how the resource guide is set up. What do you think about how it is organized or how it flows? 2. Is the presentation appealing to you? Is the manual easy to follow? 3. How do you feel about print size? 4. What about the margins or the way the words are grouped and arranged? B. Cultural sensitivity 1. What is your first impression of the resource guide? 2. What do you think about the training offered in the resource guide? How well does it help you understand how to run a peer reminiscence session?" 3. How well does it help you (peer facilitator) to ask about the kinds of memories that your peers usually share with one another?" 4. What do you think we should know about this resource guide that would make it the most acceptable to older Black adults?" C. Reminiscence Resource Guide Feasibility 1. Having read the resource guide, how well do you feel it prepares someone to run a peer reminiscence session?" 2. Having read the resource guide, do you feel able to run a peer reminiscence session right away? 3. What do you think we should know about this resource guide that would make it the most helpful and easy to use for you?"
5. Closure	A. Inform participants that the focus group session is about to end. B. Summarize the main points made and highlight any potential differences brought up during the focus group. Final questions: 1. What is the most important thing you feel we should know about this resource guide? 2. What final thoughts do you have that you feel I haven't mentioned?

Appendix C

Reminiscence Resource Guide Table of Contents