

# The Grady Nia Project: A Culturally Competent Intervention for Low-Income, Abused, and Suicidal African American Women

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Background information is provided on the link between intimate partner violence and suicidal behavior, as this association sets the stage for interventions for this population. Attention then is paid to the theoretical components of an innovative culturally competent intervention for abused and suicidal, low-income African

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American women, entitled Grady Nia Project. The intervention is guided by the theory of triadic influence. Cultural competence components essential to implementing an intervention with this unique population and guided by this model are articulated. The Grady Nia Project is then described in detail, focusing on the context in which the intervention is conducted, the content of the 10 sessions, and treatment satisfaction and outcome data. Implications for culturally informed practice with abused, suicidal African American women are noted.

*Keywords:* intimate partner violence, suicide attempts, African American women, low income, culturally competent Interventions

### *Intimate Partner Violence and Suicidal Behavior*

Intimate partner violence (IPV) is a pervasive social problem for African American women (Hampton & Gullotta, 2006). The abuse experienced by African American women is more severe and life threatening than that experienced by women of other races (Campbell, Sharps, Gary, Campbell, & Lopez, 2002). Socioeconomic status has been posited to explain the elevated rates and serious incidents of IPV among African Americans (Bent-Goodley, 2004), and young, poor women who reside in urban areas are particularly vulnerable (Rennison & Planty, 2003). Low-income, abused African American women are also at increased risk for a number of psychological and psychosocial consequences of IPV (Rennison & Planty, 2003), one of the most serious being suicidal behavior (Kaslow et al., 1998, 2002).

As many as 80% of women who attempt suicide cite an abusive partner as a causal factor and 35-40% of at-risk women attempt suicide during or after the breakup of an abusive relationship and are more likely than nonbattered women to make multiple attempts (Stark & Flitcraft, 1996). IPV more than doubles the risk of suicide attempts in African American women (Stark & Flitcraft, 1996). Compared with nonattempters, African American women attempters are 2.5 times more likely to report physical IPV and 2.8 times more likely to report nonphysical IPV (Kaslow et al., 2000). The IPV- suicide link is mediated by psychological distress, hopelessness, and drug use (Kaslow et al., 1998). Negative life events, child maltreatment, distress and depression, hopelessness, and substance use increase abused African American women's risk for suicidal behavior (Kaslow et al., 2002), whereas hopefulness, spirituality, self-efficacy, coping skills, social support, and resource attainment serve a protective function (Kaslow et al., 2002; Meadows, Kaslow, Thompson, & Jurkovic, 2005).

Historically, the bulk of IPV interventions appeared as case reports and uncontrolled studies. Recently, randomized controlled trials (RCTs) have revealed the efficacy of three types of interventions. First, postintervention and follow-up data demonstrate the value of an intensive community-based intervention that includes an advocate in terms of enhancing overall functioning and quality of life, social support, and accessing community resources, but not IPV status (Bybee & Sullivan, 2002; Sullivan & Bybee, 1999; Sullivan, Campbell, Angelique, Eby, & Davidson, 1994; Sullivan, Tan, Basta, Rumpitz, & Davidson, 1992). In these studies, approximately 20% of the women were African American. Second, support has been found for the Advancing Career Counseling and Employment Support for Survivors (ACCESS) Programs relative to a wait-list control at postintervention and follow-up with regard to self-efficacy and goal attainment, and this is most true for women receiving the program with a critical consciousness com-

ponent (Chronister & McWhither, 2006). No information is provided on the percentage of African American women in this sample. Third, RCTs on couples therapy reveal its efficacy and safety (Dunford, 2000; Stith, Rosen, McCollum, & Thomsen, 2004). Although abused African American women and the profession desire culturally relevant interventions, well-designed studies testing interventions for these women are nonexistent. Further, no RCTs have targeted abused, suicidal women.

There is also a paucity of evidence-based programs for suicidal adults. Only a few well-designed RCTs have appeared (Brown et al., 2005; Linehan et al., 2006). Research shows the value of lengthy interventions; efficacy of specific interventions; effectiveness of longitudinal contact; and the safety of outpatient treatment (Motto & Bostrom, 2001; Rhee, Merbaum, Strube, & Self, 2005; Roberts & Everly, 2006; Townsend et al., 2001). Although only a few programs reduce suicidal behavior (Brown et al., 2005; Bruce et al., 2004; Guthrie et al., 2001; Linehan et al., 2006; Motto & Bostrom, 2001), most lower risk factors and psychosocial difficulties and improve target problems and overall functioning (Brown et al., 2005; Rhee et al., 2005; Townsend et al., 2001). Most studies do not report the ethnicity, race, or income of the participants and include very low percentages of African Americans, and few studies target women. No studies target only African Americans, describe a culturally competent program, or specifically address abused, suicide attempters.

### *Theoretical Components of an Intervention for Abused, Suicidal African American Women*

Cultural norms influence women's responses to IPV and suicidality, and African American women are less likely to seek help from institutions that have contributed to their oppression (Bent-Goodley, 2004). Thus, culturally informed interventions for abused and suicidal African American women, such as the Grady Nia Project, are needed. Rather than adapting an existing intervention, we created a treatment tailored to the cultural backgrounds of our participants. This decision is in keeping with results from a recent meta-analysis, which reveals that although multicultural adaptations sensitive to many cultural groups are more effective than interventions without any modifications, optimal benefits occur when the intervention is designed specifically to take into consideration the unique cultural context of the patients (Griner & Smith, 2006). The choice to create a new intervention also is consistent with the Guidelines on Multicultural Education, Training, Research, Practice, and Organization Change for Psychologists (American Psychological Association, 2003), which underscore the value of attending to patients' unique world view and cultural background and incorporating culture-specific strategies. Further, this newly crafted intervention builds upon recommenda-

tions that clinicians incorporate culture-based meaning with their patients (Whaley & Davis, 2007).

The Grady Nia Project is guided by the theory of triadic influence (TTI; Flay & Petraitis, 1994). The TTI has been integrated by its originator and others with a risk and protective factors framework (Bell, 2006; Mann, Hosman, Schaalma, & deVries, 2004).

It has been applied to myriad public health problems, including violence (Bell & Fink, 2000; Browne, Clubb, Aubrecht, & Jackson, 2001; Komro et al., 2004) and suicide (Bell, 2006), and has been used to guide effective intervention and prevention practices. TTI describes three streams of influence, which can be risk and protective factors, that are viewed as the ultimate causes of human behavior: (a) intrapersonal, (b) social and situational, and (c) cultural and environmental. Bell and colleagues (Breland-Noble, Bell, & Nicolas, 2006) distilled the TTI model into field principles valuable for designing targeted interventions for maladaptive behaviors in low-income African American individuals. The field principles refer to (a) rebuilding the village via building community collaborations to support troubled individuals and families, (b) providing access to health care, (c) increasing connectedness, (d) enhancing social skills, (e) bolstering self-esteem, and (f) reducing the residual effects of trauma.

In accord with the TTI, sessions target reducing and enhancing intrapersonal, social and situational, and cultural and environmental risk and protective factors. In line with the field principles, the Grady Nia Project involves culturally meaningful community agencies to collaboratively support the women (cultural and environmental); assists women in accessing and negotiating a comprehensive mental health care system (intrapersonal, cultural, and environmental); bolsters bonding, attachment, and connectedness (social and environmental); enhances social skills and self-efficacy (intrapersonal); and ameliorates distress associated with trauma histories by using empowering cultural and gender relevant approaches.

The Grady Nia Project is culturally competent; it incorporates constructs from Afrocentric theory (Corneille, Ashcraft, & Belgrave, 2005) to empower women (Roberts, Jackson, & Carlton-Laney, 2000) and is guided by Black feminism/womanism, the culturally relevant form of feminist theory that addresses racial and gender dynamics (Collins, 2001; Taylor, 2005). The program name includes the word *Nia*, a Kwanzaa term that means purpose; we hope the women will find a new sense of purpose, feel empowered, and commit to living. The program uses African proverbs, attends to African American heroines and role models, and emphasizes culturally relevant coping strategies (spirituality, religious involvement) to enhance self-awareness and connection (Bell & Fink, 2000; Hampton & Gullotta, 2006; Roberts et al., 2000; Williams, 2005). It builds on the strengths of African American women, families, and communities consistent with other culturally informed interventions (Brody et al., 2006; Campbell et al., 2002; Hampton & Gullotta, 2006). Further, the group format has been advocated for African American women; it provides the opportunity to build networks for emotional and spiritual support, promote positive health, share stories, and obtain validation.

The Grady Nia Project also builds upon Black feminism/womanism approaches to be gender sensitive (Collins, 2001). It underscores the importance of womanist strategies of community building, self-determination, compassion, and empowerment through interpersonal connection and overcoming oppression

(Williams, 2005). It emphasizes overcoming negative stereotypes and establishing a healthy image of what it means to be a strong African American female (Bell & Mattis, 2000; Roberts et al., 2000). It is sensitive to the unique challenges African American women face in leaving a battering relationship, such as discrimination in the community (Taylor, 2005).

The Grady Nia Project reflects the fact that African American women possess or can access many protective factors that reduce their risk of suicide (Bell, 2006; Bell, Richardson, & Blount, 2006; Poussaint & Alexander, 2000) and takes into account that their responses to IPV reflect their experiences with racism and their social contexts (Campbell et al., 2002). Such experiences and environments often offer them with fewer effective options for resisting violence and prevent them from securing assistance from institutions that historically have safeguarded Caucasian women. Building on empirical data, the Grady Nia Project is shaped by providers' experiences with African American women and is grounded in the stories of its participants (Bell & Mattis, 2000). It is mindful of the intersections of race, class, sexual orientation, and gender (Collins, 1998), particularly with regard to IPV and suicidal behavior (Sokoloff & Dupont, 2005).

### *Grady Nia Project*

(<http://www.psychiatry.emory.edu/PROGRAMS/niaproject/home.htm>)

### *Background*

Grady Health System is a large, level 1 trauma, university-affiliated, public, urban health care system. With a 115-year mission to serve the city's poorest residents, it is a primary resource for the African American community. The Grady Nia Project includes a preintervention assessment, random assignment to the TTI-informed intervention described below versus enhanced treatment as usual, an immediate postintervention assessment, and two follow-up assessments (6 months and 1 year after intervention).

The Grady Nia Project is a 10-session, group-format intervention delivered by one African American and one non-African American therapist in an outpatient setting. It encourages collaboration with staff; incorporates individual goals; prioritizes safety needs, effective coping with IPV and its associated stresses, and empowerment; and aims to bolster adjustment outcomes. The manualized, didactic, 90-min sessions include three 30-min segments: (a) weekly check-in and IPV and suicide assessment, (b) interactive discussion of the week's topic, and (c) group activities. A brief synopsis of each session is presented below.

### *Sessions*

*Meeting 1: Introduction and commitment to safety.* Group leaders and members are introduced; the group is described; meeting binders are provided; the Resource Room is explained and toured; and personal goals for the program are developed. Emphasis is placed on developing commitments to living, working towards a violence-free family life, and the program (Rudd, Joiner, & Rajab, 2001). After viewing a DVD about success stories of prior Grady Nia Project women, to expose African American women in a positive light (Roberts et al., 2000), women share their own stories.

*Meeting 2: Suicide and IPV education.* The range of suicidal behavior, precipitants, and risk factors associated with suicidal behavior, and strategies to prevent suicidal behavior are discussed. Information is offered on the nature of IPV, cycle of violence, risk and protective factors, challenges for African American women in leaving abusive relationships, and ways to address these difficulties. Women view and discuss clips from *What's Love Got To Do With It?* and examine how suicidal behavior and IPV affects them and their families. The activity is for women to create survival kits.

*Meeting 3: Safety planning.* Women are taught safety planning for suicidal behavior (Rudd et al., 2001) and IPV (Campbell, 2002). The activity is for women to devise their personal suicide and IPV safety plans, with recognition that such plans are dynamic and need to change as circumstances shift.

*Meeting 4: Reducing intrapersonal risk factors.* Information is provided about psychological disorders that co-occur with suicide attempts or IPV. Psychiatric services and warning signs of stress are reviewed. Cognitive-behavioral and empowerment strategies for reducing depressive and anxious symptoms and positive racial identity are taught. Activities include (a) scheduling of pleasant events and using positive self-statements; (b) charting link between positive events and cognitions, improved mood and self-esteem, and reduced anxiety and substance use; (c) listing positive self-statements on calling cards; and (d) providing positive feedback to one another on cards.

*Meeting 5: Enhancing intrapersonal protective factors.* Strategies for building a philosophy for living and coping with life's challenges are offered (Rudd et al., 2001). Techniques to increase hopefulness and optimism (Seligman, Linley, & Joseph, 2004) and strategies for adaptive emotion- and problem-focused coping are taught. For women with religious/spiritual ties, religious coping is highlighted. Women are empowered by learning a problem-solving approach (Nezu, 2004) that improves depression and hopelessness in suicidal persons (Townsend et al., 2001). Group activities are (a) listing reasons for living and determining steps to increase the number of reasons to stay alive; (b) following problem solving steps regarding a topic of personal concern; and (c) drawing an image depicting self as a Goddess, sharing the pictures, overcoming negative stereotypes of African American women, and collectively calling out names of African American heroines and personal female positive mentors and role models to assist them in experiencing themselves as strong African American women.

*Meeting 6: Reducing social and situational risk factors.* Information is offered on common relationship disagreements and challenges that contribute to stress and exacerbate risk. Women are taught how to read interpersonal cues that suggest that a partner may be abusive or that the cycle of violence may be escalating. Women are helped to evaluate aspects of their relationships over which they have control and have supported in extricating themselves from the abusive relationship if they choose. The session provides specific strategies for listening, communicating, and setting limits and boundaries, as well as the safest ways to leave an abusive partner. The activity is to practice assertively conveying thoughts and feelings in the face of conflict and working towards a reasonable solution to an interpersonal dilemma.

*Meeting 7: Enhancing social and situational protective factors.* This meeting defines social support, when it is needed, and how to ask for it. For the activity, women identify types of available

support and areas in which they want increased support. They complete a Social Network Generator to determine whom they can ask for which forms of help and practice interpersonal effectiveness skills.

*Meeting 8: Reducing cultural and environmental level risk factors.* This meeting educates women about available resources, encourages them to share about helpful resources, provides strategies for obtaining help, and offers ways to overcome barriers to securing services. Negative messages from the community about seeking assistance and experiences related to discrimination are examined and ways to respond effectively are explored. The activity is the Resource Web; women ask about a resource they need help with, and others in the group provide input. Women hear from community leaders that provide services for abused women and for suicidal persons.

*Meeting 9: Enhancing cultural and environmental level protective factors.* Attention is paid to the association between securing and maintaining employment and associated reduction in suicidality and depression. Guests from community organizations that can help women secure employment provide insights and assistance. Termination concerns are addressed. As the activity, women identify areas in which they could use help and, using the Resource Room, list agencies to contact, role-play calling the agencies, and then call the agencies.

*Meeting 10: Review and termination.* This meeting focuses on group termination. Material from prior meetings is reviewed and feedback regarding the Grady Nia Project is elicited. Individualized after-care plans are discussed and T2 assessments are scheduled. Session 10 ends with a party, where women receive certificates of completion, and cards with the positive statements from Meeting 4.

### *Adjunctive services*

A number of adjunctive services are incorporated as part of the group treatment depending on the needs of each woman. These include support groups, individual and family therapy, parenting skills training, medication management, and assistance in obtaining social services. All women have access to our "Resource Room," which is stocked with donated items, such as toiletries, child-care items, and food. It also houses a library of community resources. Further, a member of the Grady Nia Project team is on call around the clock and available to each woman. Women who require more intensive psychiatric care (e.g., hospitalization, day treatment services) are provided these through Grady Health System.

### *Treatment Satisfaction and Outcome*

Data from an Intervention Satisfaction Survey reveal that the women who participate in the Grady Nia Project are extremely pleased with the services that they receive. Specifically, more than 80% of the women in the project reported that participation facilitated their capacity to talk about IPV and suicidal feelings, to cope more effectively with IPV, and to reduce their suicidality. Over 70% of the women found the Resource Room to be valuable. Overall, close to 90% of the women reported extremely high or high levels of intervention satisfaction. No specific data are available on the extent to which the participants find the unique cultural

components to be of value to them. Further, no specific data were collected regarding the extent to which the women in the project actually learned the material shared in each session. However, homework assignments were given to help the women consolidate their learning. Tip cards are also provided during each session as reminders of key study points. Postintervention and follow-up assessments include measures of the key intrapersonal (e.g., self-esteem, coping, religious coping, problem solving), social and situational (e.g., family interactions, social support), and cultural and environmental (accessing resources, gaining employment) risk and protective factors. Preliminary data indicate a reduction as expected in the risk factors and improvement as predicted in the protective factors across all three domains.

Although all of the women attempted suicide within the year prior to their participation in the Grady Nia Project, only 13% attempted suicide within the year following their enrollment in the program. Preliminary findings suggest that the Grady Nia Project is effective for abused and suicidal African American women. At postintervention and follow-up, women in the Grady Nia Project exhibited attenuated negative reactions, i.e., less suicidal ideation and depressive symptoms to stresses (i.e., physical and nonphysical IPV, daily hassles), compared to women randomized to treatment as usual. Findings suggest that the Grady Nia Project enabled the women to more effectively cope with stress and not evidence as much psychological distress in response to IPV and daily hassles. In addition, women who participated in the intervention and who became employed during or following the Project had lower levels of depressive symptoms over the course of 1 year (Mascaro, Arnette, Santana, & Kaslow, 2007).

### *Implications for Practice*

Cultural competence and evidence-based psychological practice is in its infancy, and it still needs to be determined if interventions are effective without culture modifications, which elements of interventions may be most culturally applicable, or if interventions are best when devised for a specific cultural group (Whaley & Davis, 2007). However, there are many benefits to devising and evaluating evidence-based intervention protocols for specific cultural groups, such as abused and suicidal low-income, African American women. There is evidence that interventions targeted to a specific cultural group are more efficacious than those offered to individuals from varied ethnic and racial backgrounds (Griner & Smith, 2006). Such interventions must convey an appreciation of the local sociocultural context and unique individual needs of one's clients (Lakes, Lopez, & Garro, 2006).

For the professional implementing a culturally competent intervention, the following components are essential. Therapists must strive to integrate their clients' cultural frameworks with their own cultural perspectives and coconstruct a narrative that is culturally informed and incorporates the patient's life history (Lopez, 1997). Doing so will be empowering and healing for abused, suicidal women. It will reduce their sense of hopelessness, enhance their self-esteem and sense of self-efficacy, and offer them more hope for a productive, meaningful, and violence-free life. Further, regardless of the therapist or team member's ethnic background, an understanding of the value of diversity for each person involved in the therapeutic process and a willingness to look closely at one's own cultural biases is key. Racial stereotypes held by helping

professionals can prevent African American women from receiving culturally competent therapy. Even "positive" stereotypes held by the therapist (e.g. the strong black woman) can present a barrier to services or reduces intervention effectiveness (Bent-Goodley, 2004).

Spirituality and religious participation are other important aspects of African American women's sociocultural context. Spirituality is a source of help and support for abused African American women (Short et al., 2000), and this is a source of strength that has been linked to positive healing and enhanced psychological well-being (Gillum, Sullivan, & Bybee, 2006). Abused African American women suicide attempters have lower levels of spiritual well-being than do abused nonattempters (Kaslow et al., 2002). Spirituality protects abused women from attempting suicide (Meadows et al., 2005) and religious participation protects African Americans from suicide (Griffin-Fennell & Williams, 2006). Spiritual well-being is a relevant target of therapy with this population (Arnette, Mascaro, Santana, Davis, & Kaslow, 2007).

Group treatment is one way to empower African American women (Jackson & Greene, 2000). Group therapy fosters interpersonal connectedness, enhances community resources, and builds effective coping and problem-solving approaches. It is also helpful to establish an advocate for each woman, who provides direct help in locating resources (Sullivan & Rumpitz, 1994), the attainment of which is empowering.

Interventions also are empowering when they are strength-based (Heron, Twomey, Jacobs, & Kaslow, 1997). When intervening with suicidal, African American women, therapists must be aware that traditionally thought-of risk and protective factors might not play out in the same way among members of the African American culture as with other groups. The following are protective factors that are particularly salient for African American women: hopefulness, self-efficacy, coping skills, social support, and effectiveness in obtaining material resources (Meadows et al., 2005). "Engaged" coping strategies (e.g. social support, spirituality), which involve constructive responses to a stressor, should be emphasized (Fowler & Hill, 2004).

In closing, a culturally based framework must be incorporated for conducting suicide and IPV risk assessments. When intervening with abused and suicidal African American women, health and mental health care providers should strive to be nonjudgmental and supportive, be willing to individually tailor their interventions, and convey an appreciation for the complexity of IPV and suicidal behavior (Feder, Hutson, Ramsay, & Taket, 2006). Their interventions must be attuned to the intersections of race, class, and gender (Bryant-Davis, 2007; Sokoloff & Dupont, 2005) and sensitive to the perceptions of IPV and suicidal behavior of the racial/ethnic group being served (Bent-Goodley, 2004; Nash, 2005).

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### Call for Nominations: *Health Psychology*

Division 38 (Health Psychology) is currently accepting nominations for the editorship of *Health Psychology* for the years 2011-2016. Robert M. Kaplan is the incumbent Editor.

Candidates should be members of Division 38 and of APA, and should be available to start receiving manuscripts in 2010 to prepare issues to be published in 2011. Division 38 encourages participation by members of underrepresented groups and would welcome such nominees. Self-nominations are also encouraged.

Kevin D. McCaul, Ph.D., has been appointed as Chair for this search.

To nominate candidates, prepare a statement of two pages or less in support of each candidate, and provide a current CV. Submit all materials electronically to: apadiv38@verizon.net.

The deadline for receipt of nominations is April 15, 2009.