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Coping with Depression in Single Black Mothers

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Abstract

Very little information exists in the literature about what black women do when they experience symptoms of depression. The purpose of this descriptive study was to analyze the responses of 208 community-residing black single mothers, aged 18 to 45, to an open-ended question asking, “What do you do to feel better when you are feeling down in the dumps?” The theoretical bases of the Ways of Coping Checklist, were used to facilitate categorizing their responses into a coping scale and then a particular coping profile. Percentages were used to categorize the frequency of the responses into the respective coping scale and to categorize the frequency of the combined responses of each woman into a respective coping profile. Of the 333 responses that the women provided, 327 were useable. Findings indicated that a majority of responses fell into the Escape-Avoidance category ($n = 206$; 63%), followed by the Seeking Social Support ($n = 60$, 18.3%), Positive Reappraisal ($n = 40$; 12.2%), Planful Problem Solving ($n = 12$; 3.7%), Distancing ($n = 3$; 1%), and Self-Controlling ($n = 6$; 1.8%) categories. No responses fit the Confrontive Coping or Accepting Responsibility categories and none of the responses indicated that the women sought professional help. Of the 176 women who provided answers to the study question, more than half (64.2%; $n = 113$) gave only emotion-focused responses, 2.8% ($n = 5$) gave only problem-focused responses, 2.8% ($n = 5$) gave mixed responses, and 30.2% ($n = 53$) reported social support seeking. Implications for future research, cultural theory, and nursing practice are addressed.

Disparities in access to mental health treatment, as well as in the quality of treatment for mental health care, exist in the United States and continue to disproportionately affect communities of color (National Alliance on Mental Illness [NAMI], 2006). According to a national health survey, Blacks are more likely to report symptoms of depression, yet less likely to receive mental health treatment, counseling, or treatment for a major depressive episode when compared to their non-Hispanic white counterparts (US Department of Health and Human Services, Office of Minority Health [USDHHS OMH], 2014). These facts are reflected in what we know about black single mothers, 47% to 70% of whom report depressive symptoms indicative of mild to severe clinical depression in published studies (Atkins, 2010, 2015, Hatcher, 2008, Siefert, Williams, Finlayson, Delva, & Ismail, 2007). This rate is six times the rate of depressive symptoms reported in the general population of US adults (6.9%; NIMH, 2012), up to double the rate reported in black women in general (21% to 39%; Abel & Crane, 2014, Bronder, Speight, Witherspoon, & Thomas, 2014).

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Makambi, Williams, Taylor, Rosenberg, & Adams-Campbell, 2009), and up to four times the rate reported in elderly African Americans (5.4% to 30%; Pickett, Bazelaïs, & Bruce, 2013). Despite these facts, black single mothers are rarely identified and treated for depressive symptoms (Atkins, 2015; Beaufont-Lafontant, 2007; Waite & Killian, 2009), and are hesitant to seek treatment or report depressive symptoms to health care providers (Beauboeuf-Lafontant, 2007; Waite & Killian, 2008, 2009). Clinical depression is a serious mental illness defined by its symptoms (Radloff, 1977), which negatively impact physical health, quality of life, and psychosocial functioning (Borsbo, Peolsson, & Gerdle, 2009; Coyne, 2009; Dinan, 1999; Lam et al., 2009). Clinical depression also produces negative psychosocial and health outcomes for single mothers and their families (Atkins, 2010; Boyd, Zayas, & McKee, 2006; Casey et al., 2004; Silver, Heneghan, Bauman, & Stein, 2006). To prevent these deleterious effects, it is critical to identify the factors impacting the self-recognition of depressive symptoms and the propensity to seek treatment for depressive symptoms in this vulnerable group of black women before these mothers become clinically depressed.

A growing body of theoretical literature reveals that culturally influenced ways of coping with depressed feelings may impact the self-recognition of clinically significant depressive symptoms, and the willingness to seek mental health care treatment for depressive symptoms in black women, potentially leading to a higher prevalence of untreated clinical depression in this group (Beauboeuf-Lafontant, 2005, 2007; Hunn & Craig, 2009; Jones & Ford 2008). Despite these facts, a recent search of the literature over the past 20 years produced only one quantitative report in which the investigator examined the most prevalent strategies that large samples of black women used to cope with depressive symptoms (Ward, Wiltshire, Detry, & Brown, 2013). In several qualitative reports, investigators found that instead of acknowledging depressive symptoms and seeking treatment, small purposive samples of elderly African American women (Black, White, & Hannum, 2007; Conner et al., 2010; Ward, Mengesha, & Issa, 2014) and black young adult and middle aged women (Schreiber, Stern, & Wilson, 2000; Waite & Killian, 2007, 2008, 2009) report the use of culturally endorsed emotion-focused coping strategies (Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986) when they feel depressed. Problem-focused coping strategies, such as seeking social support for information to solve the problems and seeking professional help to treat depressive symptoms, were sought as a last resort (Schreiber et al., 2000; Waite & Killian, 2007, 2008, 2009). These findings are confirmed by national health surveys that report that black women are half as likely to receive mental health treatment or counseling compared to white women (USDHHS OMH, 2014).

The sample sizes in the aforementioned qualitative reports were small and not generalizable to all black women, nor to specific subpopulations of black women, namely single mothers. Black single mothers have multiple risk factors that exponentially increase their vulnerability to depressive symptoms (Atkins, 2010, 2015; United States Census, 2012; R. Clark, Anderson, Clark, & Williams, 1999), while decreasing their available coping resources (Pearlin & Schooler, 1978). In addition, the aforementioned qualitative study designs do not allow for objective quantification to determine the most prevalently reported strategies, which is important since certain coping strategies are more strongly associated with depressive symptoms than others in single mothers (Hall, Gurley, Sachs, & Kryscio,

1991) and in African American women (Greer, 2001; Mitchell et al., 2006). A critical examination of the most prevalent ways black single mothers cope is an essential first step for developing culturally relevant theories and testing interventions to promote adaptive coping strategies and, subsequently, reduce disparities in regards to the recognition and treatment of depressive symptoms in this vulnerable group of women.

The purpose of this descriptive study, therefore, was to categorize the responses that 208 black single mothers report for coping with depressive symptoms in order to determine which coping strategies are most prevalent for this group. The individual coping profile of each woman also was examined to determine her use of problem- versus emotion-focused coping. The women responded to the open-ended question, “What do you do to feel better when you are feeling down in the dumps?” with “down in the dumps” being a culturally acceptable phrase used to describe depressive symptoms (Waite & Killian, 2007). Their responses were categorized according to the eight coping subscales in the Ways of Coping Questionnaire (Folkman & Lazarus, 1986; described in detail later). The women’s responses were part of a larger research project that tested a theory of depression via structural equation modeling in 208 black single mothers (Atkins, 2015). The sociocultural and historic contexts that influence the most prevalent ways of coping also are used to interpret these data, and implications for reducing mental health disparities are discussed.

BACKGROUND

Coping and Depression: Theoretical Framework

The theoretical basis of the “Ways of Coping Questionnaire,” developed by Folkman and Lazarus (1985) was used for this analysis. The contents of this questionnaire are based on stress and coping theories developed by Lazarus and Folkman (1984) who define coping as “a person’s constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person’s resources” (p. 993). Demands are experienced as stressful encounters, causing emotional fluctuations (Folkman & Lazarus, 1985) and chronic and acute stressors precipitate the onset of depressive emotions in women (D. A. Clark, Beck, & Alford, 1999; Gotlieb & Hammen, 2009; Hammen, Kim, Eberhart, & Brennan, 2009). The way people cope to alter the stressors affects their psychological well-being and, therefore, has the potential to affect their levels of depressive symptoms (Folkman & Lazarus, 1980, 1985).

Coping is emotion-focused when it is aimed at regulating stressful emotions and is used when a situation is appraised as out of one’s control, as something that must be accepted, and—from the person’s perspective—is not amenable to change (Folkman & Lazarus, 1980; Folkman et al., 1986). Coping is problem-focused when it is aimed at altering the person-environment relation that is causing the stressful emotions and when the situation is viewed as amenable to change (Folkman et al., 1986). Both problem- and emotion-focused coping strategies may be used in any one stressful encounter (Folkman & Lazarus, 1985, 1986). The Ways of Coping questionnaire contains 67 items that describe emotion-focused and problem-focused cognitive and behavioral strategies people use to manage internal and external demands during stressful encounters; these strategies are arranged as eight scales. There are five emotion-focused scales: (1) Escape-Avoidance (EA; wishful thinking and

behavioral efforts to escape or avoid the problem; “wished it would go away or be over with,” “tried to make myself feel better by eating, smoking, using drugs or medications, sleeping, shopping”); (2) Self-Control (SC; efforts to regulate one’s own feelings; “I tried to keep my feelings to myself”); (3) Accepting Responsibility (AR; Acknowledging one’s own role in the problem; “criticized or lectured myself”); (4) Distancing (D; efforts to detach oneself; “tried to forget the whole thing”); and (5) Positive Reappraisal (PR; efforts to create positive meaning by focusing on personal growth; “prayed ... found new faith ... rediscovered what is important in life”). There are two problem-focused scales including: (1) Planful Problem Solving (PPS; deliberate problem-focused efforts to alter the situation; “I made a plan of action and followed it”), and (2) Confrontive Coping (CC; aggressive efforts to alter the situation; “I did something that I didn’t think would work, but at least I was doing something”). The final subscale involves items aimed at Seeking Social Support (SSS). The items are problem-focused when the support is informational and aimed at solving the problem with tangible support, and emotion-focused when emotional support is sought (Folkman et al., 1986).

According Vitaliano et al. (1990), an individual’s “coping profile” is their “relative reliance on some coping strategies and de-emphasis on others” (p. 349). That is, the extent to which individuals use problem-focused versus emotion-focused coping is dependent upon the domain of the problem they face (i.e., interpersonal, physical health, job stress, etc.) (Pearlin & Schooler, 1978). Individuals with similar problems will have similar coping profiles and individuals with different problems will exhibit differences in their coping profiles. Hence, when examining homogeneous groups such as black single mothers who experience similar economic, psychosocial, and sociocultural stressors that may cause depressive symptoms (Atkins, 2010, 2015), similar coping profiles should be expected with respect to depressive symptoms.

Coping and Depression in Black Women: Sociocultural Perspectives

The items in the Ways of Coping questionnaire closely resemble the coping strategies reported by black women in the theoretical literature. According to some theorists, emotion-focused strategies (Folkman & Lazarus, 1980, 1985; Folkman et al., 1986) are culturally sanctioned for coping with depressive symptoms in black women since these women have a cultural mandate to work hard in the face of obstacles (Baker, 1995, 2001; Baker & Bell, 1999; Hunn & Craig, 2009) and show strength under distress and adversity (Beauboeuf-Lafontant, 2007). These expectations often are internalized, causing black women to deny strength-discrepant, weak feelings such as depressive emotions. Instead of asking for help or falling apart, they are expected to work through mental and physical distress and deny or hide depressed feelings with quiet acceptance and stoicism (Hunn & Craig, 2009).

These internalized cultural expectations also promote reliance on two commonly reported and culturally acceptable emotion-focused methods of coping for African Americans: having faith and receiving social support. The church often is theorized to be paramount in the psychological preservation of African Americans and a primary source of social support, providing connectedness for African American women (Hunn & Craig, 2009) and helping them to stay strong when experiencing depressive symptoms (Baker, 2001). Daily (2008)

discusses the benefits of religious coping, proposing that religious coping may serve as a buffer for African Americans, mediating the relationship between stressors and negative psychological effects. Having faith and a church association are coping strategies consistent with the Positive Reappraisal scale of the Ways of Coping Questionnaire (Folkman et al., 1986).

Coping with Depression in Black Women: Empirical Findings

Emotion-focused coping strategies predominate as frequently reported initial strategies for coping with depressive symptoms by black women of all ages in qualitative and quantitative reports. During focus group discussions and interviews (Beauboeuf-Lafontant, 2007; Nicoladis et al., 2010; Waite & Killian, 2007, 2008, 2009), small purposive samples of African American young adult and middle-aged women report coping strategies consistent with Distancing (denial, meditation, going on as if things are normal, being “strong”); Escape-Avoidance (shopping, eating, housework, drinking alcohol, doing for others, cleaning, smoking, working, exercise, yoga, keeping busy, playing with their kids); Self-Controlling (keeping things inside, keeping emotions cool, not telling others); Positive Reappraisal (going to church, believing God can help, praying, relying on one’s faith, talking to one’s pastor); and Seeking Social Support (spending time with one’s pastor, sister, or friends, and not speaking of depression with them). During interviews (Schreiber, Stern, & Wilson, 1998, 2000), small purposive samples of black Canadian young adult and middle-aged women also reported emotion-focused strategies to initially cope with depression that were consistent with Distancing (being strong, withdrawing); Escape-Avoidance (sleeping, getting involved, socializing with friends, exercising, engaging in diversionary activities); Positive Reappraisal (praying, reading the Bible, feeling God’s solace, having faith, thinking positively for new meaning); Self-Controlling (hiding it from the world, not speaking about it); and Social Support Seeking (socializing with friends, but not talking about depression). In one quantitative report (Ward et al., 2013) of 114 African American women, religious coping (Positive Reappraisal) was found to be the preferred method for coping with mental illness, compared with avoidance, seeking professional help, and using informal support networks. In all of these studies, problem-directed approaches aimed at confronting or reducing the stressors causing the depression were not reported. In addition, seeking professional help, a problem-focused strategy aimed at tackling the problem of depression as an illness, was a strategy of less than half of the samples and only used as a last resort.

During qualitative interviews, purposive samples of elderly black women also report emotion-focused strategies such as Distancing (being strong, denying problems, having resilience, hiding it); Escape-Avoidance (volunteering, staying busy, cooking, cleaning, using alcohol, using nicotine, keeping one’s mind occupied); Social Support (talking to family friends without talking about feeling depressed) (Black, White, & Hannum, 2007; Conner et al., 2010; Ward et al., 2014); Self-Controlling (not admitting depression, keeping feelings inside); and Positive Reappraisal (being religious, attending church, engaging in prayer, believing in God, having faith, consulting with clergy, reading the Bible, thinking positive) (Conner et al., 2010; Ward et al., 2014; Wittink et al., 2009). In all of these studies, the women accepted life stressors as normal and therefore did not report using problem-focused approaches to confront or reduce the problems causing the depression. In addition,

seeking professional help for treatment was not viewed as an option for managing depressive symptoms at all for these elderly black women.

Consistent with theory, black women report the use of a variety of culturally acceptable (Beauboeuf-Lafontant, 2007; Baker & Bell, 1999; Hunn & Craig, 2009) emotion-focused (Folkman et al., 1986) strategies to cope with or manage depressive symptoms (Beauboeuf-Lafontant, 2007; Waite & Killian, 2008, 2009; Ward et al., 2014). However, the sample sizes in the aforementioned studies were small and some samples contained married or partnered black women (Beauboeuf-Lafontant, 2007; Nicolaidis et al., 2010; Waite & Killian, 2007, 2008, 2009), black women of high socioeconomic status (Schreiber, Stern, & Wilson, 1998, 2000; Ward et al., 2013), and entire samples of women who were clinically depressed (Nicolaidis et al., 2010; Waite & Killian, 2007, 2008, 2009; Ward et al., 2014), all factors that influence an individual's coping repertoire (Pearlin & Schooler, 1978). The intersections of race (black), gender, (female), family structure (single), and socioeconomic status (poor) (Atkins, 2010; R. Clark et al., 1999; United States Census, 2012) that affect black single mothers create multiple adverse situational stressors and may limit the social, psychological, and economic resources available to them for developing a diverse coping repertoire (Folkman & Lazarus, 1986; Pearlin & Schooler, 1978). We, therefore, do not know if these poor, single, black women readily utilize the variety of strategies for coping reported by the aforementioned samples of black women (Atkins, 2010; Sullivan, 2006, 2008; USDHHS, 2009). To fill this gap in knowledge, this study determines the most prevalent strategies that black single mothers use to cope with or manage depressive symptoms.

METHODS

Design

This study was part of a larger analysis that had a descriptive cross-sectional design, that tested a theoretical model of depression in black single mothers, described elsewhere (Atkins, 2015).

Sample

A sample of convenience of 208 black single mothers who met the following inclusion criteria (a) 18–45 years of age, (b) self-identifying as black, (c) having children living with them, (d) widowed, divorced, separated, or never married, (e) physically and mentally able to participate in the study, and (f) able to read and comprehend the English language. Excluded were those (a) taking antidepressant medication, (b) currently receiving psychiatric care or counseling, (c) who were pregnant, or (d) had children less than one year of age. Sample size determination is described elsewhere (Atkins, 2015). Of these mothers, 176 provided usable answers to the one interview question, “What do you do to feel better when you are feeling down in the dumps.”

The present study sought to identify the most prevalent coping strategies by answering two research questions:

Research Question 1—What are the most prevalent strategies used by black single mothers to cope with depressive symptoms?

Research Question 2—Do black single mothers individually report having only problem-focused, only emotion-focused, or mixed (problem- and emotion-focused) profiles for coping with depressive symptoms?

Procedure

After approval was received from the university's Institutional Review Board, a convenience sample of 208 community-dwelling black single mothers was recruited from ten different recruitment sites over a three-month period, June 2012 to September of 2012. The sites included three social service agencies, three private pediatric practices, and four community sites in two-inner city communities. Exactly 312 women were approached in person and asked to participate and 226 women completed the surveys. Eighteen women were excluded because they did not meet the inclusion/exclusion criteria. Although 208 black single mothers completed the survey packets, only 176 of these mothers provided answers to the study questions for this analysis. After completing data relevant to this larger study (Atkins, 2015), the women responded to the study question. Two spaces were given so that the women were given the opportunity to provide more than one strategy for coping with depressive symptoms.

Data Management

To categorize the data for the first question, a 9×24 dimension table was constructed and labeled from 1–208, corresponding to each participant in the study. Two spaces were provided to allow room for two possible answers to the study question. The responses to the study questions were placed in the table within the box(es) next to the number corresponding to each respective participant. After reviewing the response, initials for the coping scale (i.e., D, AR, CC, PPS) consistent with the response were then placed within the box next to each response, based on the judgment of the reviewer (i.e., Pray, = Positive Reappraisal). The response categories (i.e., D, AR, CC, PPS) were then listed in a separate table. Tally marks were used to total the number of responses corresponding to its appropriate category; the final number was totaled for each respective category, and that number was placed next to the category (i.e., D = 3, PR = 40). Two doctorally-prepared nurse researchers completed the aforementioned procedures separately and there was 99% agreement between them. The principal investigator, based on knowledge of coping theories for black single mothers, decided the appropriate category for two answers that were not agreed upon. To categorize the data for the second question, six categories were made. These were: (1) Only Emotion-Focused, (2) Only Problem-Focused, (3) Emotion-Focused and Problem-Focused, (4) Only Social Support Seeking, (5) Social Support Seeking and Problem-Focused, and (6) Social Support Seeking and Emotion-Focused. The categories were not mutually exclusive since the purpose of social support seeking (i.e., receiving emotional support versus receiving information to solve the problem) was not able to be determined by the answers given (i.e., “talked with family and friends”). Each woman's response was then labeled with an appropriate coping profile based on the chosen scale(s) for that response. The categorization of the coping profile was completed by just one reviewer since the coping scales are already defined as either emotion-focused, problem-focused, or both, based on the stress coping theory (Folkman et al., 1986).

Data Analysis

The responses were analyzed using the SPSS 21 computer program. The coping categories (i.e., D = 1, AR = 2, PPS = 3, CC = 4) were entered into the SPSS computer program's "variable view" and labeled one to eight. The women's responses (coping strategies) were then entered into the "data view" of SPSS according to the categories, one to eight, agreed upon by the reviewers. Two columns were used, one for the first coping strategy and one for the second coping strategy offered. Similarly, the six coping profiles were entered into "variable view" and numbered one to six. The profile category assigned to each participant was then entered into "data view" in the box corresponding to each participant. Only one column was used for the coping profiles. Percentages were used to categorize the frequency of the responses into the respective coping scale for all women providing one or two responses to the study question. Percentages also were used to categorize the frequency of the combined responses of each woman into the respective coping profile. The final product was a table of the percentage of all responses within each coping scale (see Table 1) and a table of the percentage of all women associated with a particular coping profile (see Table 2).

RESULTS

Out of the 208 women participating in the study, 176 provided a total of 333 responses to the study question. Only 327 responses were usable as exactly 149 women gave 2 different coping strategies (298), 1 woman gave 3 different coping strategies (3), and 26 women gave 1 coping strategy (26) for a total of 327 different usable coping strategies. Six responses were not used as they involved action words or unintelligible phrases not relevant for placement in either scale in the Ways of Coping Questionnaire (e.g., "eagered," "not down").

The study participants were black mothers of diverse cultural backgrounds who self-identified as black on the demographic data sheet in the original study. The mothers were between the ages of 18 to 45 ($M = 30.55$, $SD = 7.08$). The majority of women (87.5%) reported that they were single, having never been married; 6.7% were divorced; 5.3% were separated; and .5% were widowed. The majority (88.9%) reported being the head of household. A majority (61.4%) had completed high school, 7.9% completed a technical school, 13.0% completed a two-year college, 3.9% completed eighth grade, 1.9% completed a four-year college, and 1.9% earned a master's degree. A large minority (41.9%) of mothers were unemployed and 37.9% worked full-time, 15.3% worked part-time, 4.4% were disabled, and .5% reported working temporarily. A more detailed description of the sample is reported elsewhere (Atkins, 2015). In the original study, exactly 50% of the 176 mothers who provided usable answers for this analysis had a score of 16 or higher on the Centers for Epidemiologic Studies Depression Scale (Atkins, 2015; Radloff, 1977). This score indicates clinically significant depressive symptoms (Radloff, 1977).

Question 1

The statistical findings indicated that, collectively, a majority of the responses fell into the Escape-Avoidance ($n = 206$; 63.0%) emotion-focused category. Samples of these responses

included shopping, eating, drinking, sleeping, dancing, listening to music, and playing with children. Other strategies included Seeking Social Support ($n = 60$; 18.3%), Positive Reappraisal ($n = 40$; 12.2%), Planful Problem Solving ($n = 12$; 3.7%), Self-Controlling ($n = 6$; 1.8%), and Distancing ($n = 3$; 1.0%). Samples of these responses included, meditation (D), getting money (PPS), getting housing (PPS), counting to ten (SC), praying (PR), going to church (PR), and talking to family and friends (SSS). Responses associated with faith or religiosity (faith, spirituality) fell under the Positive Reappraisal coping scale and consisted of only 32 (9.8%) out of 327 responses. No responses fit the Accepting Responsibility or the Confrontive Coping categories and only one response indicated a problem-focused act, which may have been associated with seeking professional help (i.e., medications). See Table 1 for a summary of the percentages of responses in each category.

Question 2

When the responses of each of the 176 women were analyzed individually, 64.2% ($n = 113$) gave one or two answers that were solely emotion-focused responses (i.e., EA, D, PR, SC), while only 2.8% ($n = 5$) gave one or two answers that were solely problem-focused (PPS, CC). An additional 2.8% ($n = 5$) gave one answer that was emotion-focused and one answer that was problem-focused. Exactly 30.2% ($n = 53$) gave an answer that involved Seeking Social Support, which may be either problem- or emotion-focused. Of the women providing social support seeking strategies, nine provided only SSS responses, one provided a Seeking Social Support response plus a problem-focused strategy, while 43 provided a SSS response plus an emotion-focused strategy. Responses associated with faith or religiosity (faith, spirituality) fell under the Positive Reappraisal coping scale. Individually, only 27 (15%) of the 176 mothers gave responses associated with religion, such as praying and going to church. A summary of the percentages of women associated with a particular coping profile are presented in Table 2.

DISCUSSION

This study identified the most prevalent strategies that a large community-dwelling sample of black single mothers used to cope with or manage depressive symptoms; this had not been done in previous empirical work. The reported strategies for coping with depressive symptoms were consistent with the Escape-Avoidance, Distancing, Positive Reappraisal, Self-Controlling, and Seeking Social Support scales of the Ways of Coping Questionnaire, and had been similarly reported by black women in prior qualitative studies (Schreiber et al., 2000; Waite & Killian, 2007, 2008, 2009; Ward et al., 2013). Consistent with prior small samples of black women (Beauboeuf-Lafontant, 2005, 2007; Schreiber et al., 2000; Ward et al., 2013), no strategies associated with the Confrontive Coping or Accepting Responsibility scales were reported in this larger sample. In addition, strategies associated with the Planful Problem Solving Scale, aimed at addressing the problem causing the depressive symptoms, were reported by a small percentage of the present sample ($n = 12$, 3.7%). Planful Problem Solving, however, was reported as a last resort aimed at seeking professional help to address the depression in prior samples of black women (Schreiber et al., 2000; Waite & Killian, 2007, 2008, 2009; Ward et al., 2013).

Collective Responses

Escape-Avoidance—When faced with depressive symptoms, the overwhelming majority of black single mothers employ emotion-focused cognitive and behavioral Escape-Avoidance strategies (63%) to cope with depressive symptoms. As discussed by theorists, these EA strategies may be viewed as culturally acceptable by black single mothers since they help to deny, mask, or suppress depressive emotions (Beauboeuf-Lafontant, 2007; Hunn & Craig, 2009; Jones & Ford, 2008), as opposed to strategies aimed at acknowledging depressive symptoms and their role in it (AR), tackling the cause (CC, PPS), or seeking professional help (PPS) to treat the depression (Folkman et al., 1986). The latter strategies would require acknowledging depressive symptoms as the first step, which rarely occurs in black women. Though black women in qualitative studies similarly report giving priority to mostly emotion-focused strategies, including Escape-Avoidance, to cope with depressive symptoms, the lack of quantification and categorization of the strategies precludes objective comparisons regarding the preferred coping strategies with this subpopulation of black single mothers. However, consistent with these samples of black women (Schrieber et al., 2000; Waite & Killian, 2007, 2008, 2009; Ward et al., 2013), problem-focused strategies, including seeking professional help, were not a priority coping method. Dysfunctional coping styles have been reported as barriers to seeking health care for depressed African Americans (Cruz, Pincus, Harman, Reynolds, & Post, 2008). Exactly 50% of this sample of mothers reported levels of depressive symptoms consistent with a diagnosis of clinical depression (16; Radloff, 1977). Perhaps use of the preferred EA coping methods causes delays in seeking the professional help needed to treat depressive symptoms in this vulnerable group of women.

Avoidant coping may be ineffective for relieving depressive symptoms in black single mothers. Avoidant styles of coping have been associated with higher levels of depressive symptoms in mixed race low-income single mothers (Hall et al., 1991) and in African American women in general (Mitchel et al., 2006). However, in other studies, no association between avoidant coping and depressive symptoms was found in mixed race single mothers (Samuels-Dennis, 2007), and a weak negative correlation between emotion-focused cognitive debriefing and depressive symptoms was found in a sample of female African American college students (Greer, 2011). These results are equivocal and, therefore, the nature of this relationship in black women requires further exploration. For single mothers, this relationship needs to be tested.

Seeking Social Support—Seeking Social Support was the second most frequent response (18.3%) collectively; reported by only 30% ($n = 53$) of mothers individually. This is surprising since social emotional-support seeking is frequently reported as an effective, culturally acceptable, way of coping with depressive symptoms for black women (Amankwaa, 2003; Hunn & Craig, 2009; Waite & Kilian, 2007). Perceiving that one is supported socially has been shown to reduce depressive symptoms in low-income African American single mothers (Coiro, 2001; Siefert, Williams, Finlayson, Delva, & Ismail, 2007), and in multi-ethnic mothers (Gjesfield, Greeno, Kim, & Anderson, 2010). However, the findings in the present study are consistent with empirical reports that find that single mothers often report low levels of social support (Atkins, 2010; Howell, Mora, & Leventhal,

2006; Silver et al., 2006). Some investigators have found that specific types of support, and the expectations associated with support, are more important in coping with depression and other life stressors in African American women (Amankwaa, 2003) and African American single mothers (Siefert, Williams, Finlayson, Delva, & Ismail, 2007). The value of specific types of social support, and the barriers to utilizing support networks, from the perspective of black single mothers warrants further investigation.

Positive Reappraisal—Positive reappraisal, which involves the use of religious coping strategies (e.g., prayer, church attendance, etc.), was the third most frequent response, collectively (12.2%; $n = 40$); with only 32 responses, from 27 (13%) mothers, individually, indicating religiosity in the present sample. These findings are surprising since the church is often theorized to be paramount in the psychological preservation of African Americans and a primary source of social support, providing connectedness for African American women (Hunn & Craig, 2009). Religious coping was found to be a preferred method of coping in a sample of community-dwelling African American women over and above seeking professional help, informational support, and avoidance strategies (Ward et al., 2013). Religious coping is frequently reported by African Americans as extremely important and more effective for treating depressive symptoms than counseling or medications (Cooper et al., 2001; Givens, Houston, Van Voorhees, Ford, & Cooper, 2007). However, other studies show that persons of lower income have lower participation in organizational religiosity (McCloud, 2007; Schwadel, 2008; Sullivan, 2006) and persons of higher income have greater church attendance (Nelson, 2009; USDHHS, 2009). Since black single mothers are poor (United States Census, 2012), their lack of financial resources may be associated with their inability to take advantage of the support networks available at church, hence limiting the effects of religiosity afforded African Americans in general.

Planful Problem Solving, Accepting Responsibility, and Confrontive Coping—Active forms of coping, such as Planful Problem Solving strategies were infrequently reported ($n = 12$; 3.7%), and no one reported strategies that involved Accepting Responsibility or Confrontive Coping. In addition, only one mother gave an active problem-focused response that would indicate seeking professional treatment (i.e., medication) for depression. These more active forms of coping have been typically associated with lower levels of depressive symptoms in black women (Abel & Crane, 2014; Bronder et al., 2014), and African American adults (McDougald et al., 2009; Zea, Belgrave, Townsend, Jarama, & Banks, 1996). According to Folkman and Lazarus (1985), problem-focused coping is used in encounters in which outcomes are appraised as controllable with the potential for effecting change. As is evident by the overwhelming emphasis on emotion-focused strategies, it is safe to say that black single mothers may have low perceived control over changing depressive symptoms or the problems that contribute to their depressive symptoms. Dysfunctional coping strategies that were emotion-focused were cited as a barrier to seeking health care for African Americans (Cruz et al., 2008; Ward, Clark, & Heidrich, 2009). Future qualitative studies should elicit rationales for the lack of problem-focused coping, as well as ask black single mothers about barriers to health care-seeking for depressive symptoms from their perspectives.

Individual Responses

The majority of the responses given by black single mothers for managing depressive symptoms were emotion-focused strategies (78%; Escape-Avoidance [63.0%], Positive Reappraisal [12.2%], Self-Controlling [1.8%], and Distancing [1.0%]). Even when given the opportunity to provide responses indicative of two different coping profiles, the majority of mothers individually reported only emotion-focused coping strategies ($n = 113$; 64.2%), indicating an emotion-focused coping profile (Folkman et al., 1986). A small minority provided only problem-focused coping strategies (2.8%; $n = 5$). Even if the percentage of women giving solely problem-focused responses were increased by adding all of the responses for Seeking Social Support (30.2%; $n = 53$) it would still only equal 33.0% ($n = 53$); assuming the goal of solving the problem, the percentage of women employing solely emotion-focused strategies would still be greater (64.2%; $n = 113$). In addition, 44 women who provided Seeking Social Support responses also gave an additional problem- or emotion-focused response, potentially placing them with the five women who gave mixed responses (one emotion- and one problem-focused). If added together, this would bring the mixed response category to 27% ($n = 49$), which would still be less than the number of women providing solely emotion-focused coping strategies (62.7%; $n = 94$).

Investigators have found that problem-solving coping generally decreases as depressive symptoms increase in Caucasian adults (Billings & Moos, 1984; Fondacaro & Moos, 1989). Nevertheless, samples of depressed Caucasian women have reported problem-focused strategies such as Confrontive Coping and Accepting Responsibility for managing depressive symptoms (Folkman & Lazarus, 1986). In addition, samples of immigrant and refugee women have reported Planful Problem Solving strategies (i.e., managing problems, setting goals) as primary ways of coping with depressive symptoms (O'Mahony, Donnelly, Bouchal, & Este, 2013). Emotion-focused strategies are appropriate in situations appraised as out of one's control, as situations that must be accepted, and—from the person's perspective—are not amenable to change (Folkman et al., 1986). Perhaps black single mothers are influenced by cultural expectations to show strength, which obliges them to accept depressive symptoms as a non-modifiable normal part of life (Beauboeuf-Lafontant, 2005, 2007; Hunn & Craig, 2009; Jones & Ford 2008). These mothers, thereby, avoid efforts to change the problem or source of the depressive symptoms, do not blame themselves for the problems causing the depressive symptoms (Accepting Responsibility), nor do they address the depression by seeking professional help (Planful Problem Solving).

LIMITATIONS OF THE STUDY

This study utilized a sample of convenience, which is inherently biased. In addition, 26 of the 176 women who provided responses to the study question, only provided one response. Therefore it is not known if these women only use one strategy to cope with depressive symptoms or if they use a variety of strategies and just listed one. In addition, although theory drove the quantitative analysis, subjectivity was involved with the placement of responses into a particular category. The potential that researcher bias may have affected the results, therefore, cannot be ruled out.

CONCLUSION AND IMPLICATIONS

This sample of black single mothers overwhelmingly relies on emotion-focused strategies to cope with or manage depressive symptoms. They additionally do not seek out professional treatment for depression. The nature of the relationship between these emotion-focused strategies and depressive symptoms needs to be explored to determine if these coping strategies increase or decrease depressive symptoms or hinder health-seeking for depressive symptoms in black single mothers. It also is necessary to utilize qualitative methods to ascertain why problem-focused strategies are not utilized by black single mothers. Explanations need to be formulated and interpreted via inductively derived cultural theories developed to explain coping with depressive symptoms for black single mothers. Although religiosity and social support are culturally acceptable, and frequently reported as effective ways to manage depressive symptoms in African Americans, these were infrequently reported as coping strategies in this sample. Qualitative studies are necessary to ascertain the value of social support and religiosity in managing depressive symptoms from the perspective of black single mothers. Quantitative strategies should explore the effectiveness of these strategies for reducing depressive symptoms in these women as well. Health professionals also should reach out to black single mothers, and be aware of the need to assess for high levels of depressive symptoms, especially when these mothers seem to be calm and strong despite overt adversities in their lives. Implications for nursing practice include emphasizing adaptive coping methods to ameliorate depressive symptoms. There is substantial evidence that increasing participation in physical activity lowers depressive symptoms in US adults (Josefsson, Lindwall, & Archer, 2014; Physical Activity Guidelines for Americans, 2008; Stanton & Happell, 2014), including black women (Torres, Sampsel, Gretebeck, Ronis, & Neighbors, 2010). Since these mothers do not seek medical treatment for depressive symptoms, perhaps targeting specific mental health promoting practices, such as physical activity, may hold promise for preventing and reducing depressive symptoms in these mothers. Barriers to mental health care-seeking behaviors also should be explored in black single mothers using a health promotion framework.

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TABLE 1

Coping Strategies

Coping Strategy	Examples of Participant Responses	Responses (N = 327)	% Total
Emotion-Focused		255	78.0%
• Escape-Avoidance	Exercise, eat, drink play with kids, shop sleep, dance, read, take a walk, play basketball		206
• Positive Reappraisal	Pray, go to church, happiness god, read bible, positive talk	40	12.2%
• Self-Controlling	Count to 10	6	1.8%
• Distancing	Don't think about it, have "me" time	3	1.0%
Problem-Focused		12	3.7%
• Planful Problem Solving	Plan a way out, get money, pay day, bills paid	12	3.7%
Emotion- or Problem-Focused		60	18.2%
• Social Support Seeking	Talk with family/friends, go out with friends, call Grandma, talk to kid	60	18.3%

TABLE 2

Individual Coping Profiles

Coping Profile	Scale Examples	Women (n)	% Total
Number of Participants		176	
Emotion-Focused Only	EA and EA	113	64.2%
Problem-Focused Only	PPS and CC	5	2.8%
One Emotion- and One Problem-Focused	EA and PPS	5	2.8%
Emotion- or Problem-Focused	SSS	53	30.2%

ES = Escape-Avoidance, PPS = Planful Problem Solving, CC = Confrontive Coping, SSS = Seeking Social Support