Article

Resilience, Cultural Beliefs, and Practices That Mitigate Suicide Risk Among African American Women Veterans

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Abstract

To our knowledge, no studies have examined protective factors for suicide among African American women Veterans. We conducted a qualitative study to identify and describe cultural beliefs and practices that mitigate suicide risk among African American women Veterans. Our sample included 16 African American women Veterans (*M* age = 53.3) eligible to receive Veterans Health Administration care. The following three themes emerged as being protective against suicide: (a) resilience, (b) social support, and (c) religion. Women described developing resilience from exposure to adversity. Social support primarily entailed informal assistance from family and friends. Finally, religion comprised three subthemes: faith in God, personal practices, and religious beliefs. Results underscore the importance of specific cultural beliefs and practices as being protective against suicide among African American women Veterans.

Keywords

women Veterans, African American, suicide, culture, resilience, qualitative

Current Armed Forces members are more than twice as likely as members of the general population to die by suicide (Department of Defense [DoD] Task Force on the Prevention of Suicide by Members of the Armed Forces, 2010). Suicide is also the second leading cause of death among individuals in the U.S. Armed Forces (Bryan, Jennings, Jobes, & Bradley, 2012). Although efforts within the DoD and Department of Veterans Affairs (VA) have focused on understanding how to prevent suicide among Service Members and Veterans (including identifying drivers of suicidal self-directed violence [SDV]), the majority of research has centered on men, due to the fact that men generally are far more likely than women to die by suicide. However, a recent study conducted by the U.S. Department of VA found the suicide rate among women Veterans is approaching that of male Veterans. The 2015 report, which drew data from the VA's Suicide Repository as well as death information from 23 states, indicated that among those who have never served in the military, women (5.2 per 100,000 lives) kill themselves far less than men (20.9 per 100,000 lives; Hoffmire, Kemp, & Bossarte, 2015). However, there is less disparity in suicide rates between Veteran women (28.7 per 100,000 lives) and Veteran men (32.1 per 100,000 lives; Hoffmire et al., 2015).

Though it is not clear what is driving the increase in suicide rates among women Veterans, recent findings suggest suicide rates may have more to do with who chooses to join the military than what happened during their service (e.g., deployment, military sexual trauma). The largest study of mental health and resilience ever conducted among military personnel found that men and women who join the military are more likely to have endured difficult childhoods, including emotional and sexual abuse (Kessler et al., 2014). In addition, this study revealed Army personnel had elevated rates of suicide ideation (Nock et al., 2014), suicide attempts (Nock et al., 2014), and various mental health problems (e.g., attention deficit hyperactivity disorder, intermittent explosive disorder, and substance use disorder) prior to enlistment (Kessler et al., 2014).

The gender differential in suicide rates becomes even more complex when culture is considered, suggesting that there is far more diversity across cultures than there is between genders. This is potentially problematic considering the U.S. Armed Forces has become increasingly diverse in terms of race and gender composition (Kang et al., 2015). For example, African American men make up 30.7% of the Armed Forces (Patten & Parker, 2011). Furthermore, despite the fact

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that approximately 14.2% of the Armed Forces are comprised of women, African American women (AAW) represent nearly one third of these women (Patten & Parker, 2011). Despite this substantial presence, of all Veterans who died by suicide from 2009 to 2012, only 4.5% were African American (Kemp & Bossarte, 2013), suggesting that African American Veterans are less likely to die by suicide. Although to our knowledge government data do not separate suicide rates among African American Veterans by gender, among the general population, AAW have the lowest suicide rate of any group (Curtin, Warner, & Hedegaard, 2016). Supporting this notion, recent data suggest that being male, White, or of junior enlisted rank put individuals at the highest risk for suicide (Schoenbaum et al., 2014). Furthermore, Nock et al. (2014) found the only significant association between race/ethnicity and lower odds of suicidal ideation was among non-Hispanic Blacks. Taken together, these findings suggest that AAW Veterans may be at lower risk for suicide than other cohorts of Veterans. As such, focusing on this population may enhance our understanding of modifiable protective factors for suicide and, ultimately, novel suicide prevention strategies.

Previously, several theories have been posited to explain the lower incidence of suicide among African American civilians, with a specific focus on culture as a protective factor. Culture can be defined as the characteristics and knowledge of a particular group of people, defined by language, religion, social habits, music, and arts, and expressed by shared patterns of behaviors and interactions, cognitive constructs, and understanding learned by socialization (Leong & Leach, 2008). It has been proposed that, for many African Americans, the most important protective factor against suicide is religiosity, or a strong conviction condemning suicide as sinful (Early & Akers, 1993; Gibbs, 1997; Molock, Puri, Matlin, & Barksdale, 2006). Consistent with this notion, researchers have found that lower suicide rates among African Americans are partially explained by a strong belief that suicide is an unacceptable option no matter how dire one's life circumstances (Early & Akers, 1993; Stack, 1998). Others have proposed that African Americans' high rates of participation in churches and religious communities, in addition to social belongingness, may be protective against suicide (Carrington, 2006; Waite & Killian, 2008). Researchers have theorized that African Americans, particularly AAW, condemn suicide because it is contradictory to their value systems (Ellis & Range, 1991; Neeleman, Wessely, & Lewis, 1998).

Other theories have embodied the idea that AAW are perpetually tough and uniquely indestructible. In one study, African American pastors asserted that African Americans have developed a "culture of resiliency" (Early & Akers, 1993, p. 288) in response to constant historical and present-day struggles. This resilience may differentiate African Americans from others in their response to stress. Similarly, others have proposed that African Americans deeply value survival and triumphing over adversity, despite facing hardships, such as racism and poverty (Ellis & Range, 1991; Kaslow et al., 2000). The notions of resilience and survival hold particular relevance to AAW, who have been the backbones of African American families and communities (Collins, 2006).

Although these theoretical assumptions provide possible explanations for the lower incidence of suicide among African Americans, an understanding of how culture may protect African Americans from suicide has not been established. Moreover, the suicide rate has recently increased among civilian African American men (Centers for Disease Control and Prevention National Center for Injury Prevention and Control Web-Based Injury Statistics Query and Reporting System, 2014), calling into question whether culture affects African American men and women differently. In addition, research has examined protective factors for suicide among AAW and among Veterans; yet research has not bridged these areas. To our knowledge, no studies have examined protective factors for suicide among AAW Veterans.

Furthermore, the limited research conducted on protective factors among African Americans has typically focused on AAW with a history of interpersonal violence, and has been primarily quantitative, with a few exceptions (c.f. Borum, 2012). For example, Meadows, Kaslow, Thompson, and Jurkovic (2005) used quantitative methods to establish that hope, spirituality, and self-efficacy serve as protective factors against suicide attempt risk among AAW experiencing intimate partner violence. Other protective factors examined through quantitative methodology include coping skills and effectiveness in obtaining material resources (Kaslow et al., 2002). Research questions that arise in quantitative frameworks usually address questions of "what and how many," rather than "why and under what circumstances." To develop prevention strategies and programs to strengthen protective factors, research must expand upon the standardized questions asked in quantitative questionnaires and begin to evaluate the meaning and context around responses through qualitative interviews (Hjelmeland & Knizek, 2010). Qualitative research has been noted for its ability to explore phenomena difficult to address with quantitative methods (Chwalisz, Shah, & Hand, 2008).

Phenomenological qualitative studies emphasize the importance of subjective experiences that may be overlooked with other methods of empirical inquiry. In using a phenomenological approach, researchers strive to limit the impact of structural and normative assumptions on results, which can advance treatment and policy changes for a particular phenomenon (Canetto & Lester, 1998). To address these gaps in the literature, the present study sought to examine protective factors—specifically related to cultural beliefs and practices—that may buffer against suicide risk among AAW Veterans, employing qualitative methodology.

Our objectives were to (a) examine resilience and culture among AAW Veterans and (b) uncover protective features that prevent suicide in this population. For the purpose of this study, culture is defined as beliefs, behaviors, and values. As this was an exploratory qualitative study utilizing a phenomenological approach, hypotheses are not provided.

Method

Sample

Participants included AAW eligible to receive care in a VA Medical Center in the Rocky Mountain Network. To be included, participants had to identify as cisgender female and African American or Black, aged 18 to 65, and meet eligibility for care in the local healthcare system. The study excluded women who were currently pregnant, were unable to respond to questions regarding informed consent, had a history of same-day drug or alcohol use, were actively psychotic or in a manic episode, had significant cognitive impairment that would preclude participating in the study, or if the research team determined participating would be harmful to the individual.

Recruitment

All procedures were approved by the local institutional review board. Participants were recruited from the local VA Medical Center, and snowball sampling was the primary recruitment strategy. A key informant assisted with recruitment by dispersing the study flyer. All participants who contacted the research team were screened in-person or by telephone to assess eligibility. Electronic medical records were used to confirm eligibility. Sixteen AAW Veterans participated in an in-person study visit, during which they completed consent and study procedures (i.e., qualitative interview, demographics form, and self-report measures). Participants were compensated US$50 for their participation.

Semistructured Interview

The semistructured interview is an established tool used to obtain in-depth information regarding predetermined and organized items (Baumbusch, 2010; DiCicco-Bloom & Crabtree, 2006; Whiting, 2008). This type of tool served as the primary means of data collection. Authors B.A.D.H. and L.L.M. developed the interview guide with a focus on topic areas of interest relevant to cultural beliefs and practices, including identity, protective factors, and reasons for living. The questions that were developed are detailed in the appendix.

Consistent with best practices in qualitative methods, all interviews were scheduled in advance and audio-recorded. The interviewers (B.A.D.H. and L.L.M.) followed the interview guide, while also allowing for additional questions following participant responses (Baumbusch, 2010; DiCicco-Bloom & Crabtree, 2006; Whiting, 2008). Each interview took approximately 1 hour to complete. All were transcribed, de-identified by the lead author and a research assistant, and reviewed for accuracy prior to data analysis. Accuracy review was accomplished by the lead author and research assistant reviewing one another's transcriptions to ensure correct dictation of audio recordings. Any necessary changes were made during this process, and final versions were saved for review. All original transcripts were retained. Processes described below were used to assess whether the sample size was sufficient to achieve informational redundancy (Onwuebuzie & Leech, 2007).

Data Analysis

Qualitative interviews are traditionally analyzed through a coding process such that themes are identified as they emerge from the data. Rigor of analysis (e.g., increased validity) was strengthened by implementing (a) audit trails, (b) coding forms, and (c) independent coding by multiple reviewers. For example, prior to analysis, team members met to prepare for independent review and discussed the process of theming the data (Saldana, 2016) and the use of an inductive approach. Team members also independently documented any biases held regarding expected findings. These documents were reviewed by the team during group analysis described below. In addition, the lead author (B.A.D.H.) developed a coding form. During the meeting noted above, reviewers discussed the form and provided suggested areas for change. The final form included (a) themes, (b) notes, (c) reviewer impressions, and (d) select quotes.

De-identified transcripts were analyzed through thematic analysis (Braun & Clarke, 2006), a common qualitative method that involves searching for patterns and themes within a dataset. Thematic analysis allows categories to emerge from the data and requires reflection on participant meanings and outcomes. This involved reading each transcript multiple times to note initial impressions and discern significant statements. Individual transcripts were coded using in vivo and descriptive coding. Reviewers recorded analytic memos for each transcript, in addition to tracking codes and experiences that best represented the phenomenon of African American culture from the voice of the participants.

Analysis Meeting

A one-time, in-person meeting began with each team member reviewing their experiences with the content of the data and their approach to categorizing (e.g., using keywords, phrases, and topic areas). The remainder of the meeting was focused on discussing codes and theme identification within and across transcripts. Specifically, significant statements were placed into common groups of meaning and overlapping statements were eliminated. This process is described as "horizonalization" (Creswell, 2011, p. 82). Themes were included when team members achieved consensus regarding the presence and/or salience of a given code in relation to the aim of the study. Principal subthemes were identified, as well as evidence that supported each subtheme, both quantitatively and qualitatively. As information was organized for each theme, reviewers interpreted responses to validate or reject emerging conclusions. Statements capturing personal accounts of "how, why, and under what circumstances" African American culture is significant for women Veterans'

experiences with suicidality created "textural" and "structural" descriptions of this phenomenon and provided descriptions of shared meaning, or the overall "essence" of the role of culture (Creswell, 2011, pp. 193-194). Categories were compared to identify central themes of participants' personal experiences, and the essential themes were reviewed extensively to foster a greater depth of understanding of the phenomenon of African American culture. Through discussion, consensus was achieved regarding unique and universal themes as well as their relationship to interview topic areas of interest.

Results

Sample Characteristics

Sixteen women participated in the study in March and April 2014. Demographic characteristics are presented in Table 1. Most participants were middle-aged and single, divorced, or separated. The majority had been unemployed and homeless at some point in their lives, though few were currently homeless. Nearly all participants reported their religious affiliation as Protestant, and half reported attending religious meetings weekly. Military characteristics are reported in Table 2. Most participants served Active Duty in the Army—all serving post-Vietnam or during Desert Storm/Shield. Nearly all participants were of enlisted (rather than officer) status when separated from the military. Although most did not deploy, those that did deployed once. None reported exposure to combat.

Table 1. Demographic Characteristics (N = 16).

Characteristic	n (%) or M (SD)
Age	53.3 (6.2)
Ethnicity	
Not Hispanic/Latino(a)	15 (93.8%)
Hispanic/Latino(a)	1 (6.3%)
Marital status	
Married/cohabitating	2 (12.5%)
Single	7 (43.8%)
Widowed	1 (6.3%)
Divorced/separated	6 (37.5%)
Sexual orientation	
Gay/lesbian/queer	4 (25.0%)
Heterosexual	10 (62.5%)
Bisexual	1 (6.3%)
Other	1 (6.3%)
Employment	
Full-time	4 (25.0%)
Part-time	1 (6.3%)
Retired or disabled	2 (12.5%)
Unemployed (seeking and not seeking employment)	9 (56.3%)
Current student	2 (12.5%)
Current homelessness	
Not homeless	12 (75.0%)
Homeless	4 (25.0%)
Lifetime episodes of homelessness	
None	6 (37.5%)
One or more	10 (62.5%)
Number of lifetime episodes of homelessness[a]	3.2 (2.7)
Religious affiliation	
No religious affiliation	2 (12.5%)
Protestant	14 (87.5%)
Frequency of attending religious meetings	
1 or more times a week	8 (50.0%)
1 or more times a month	1 (6.3%)
Less than once per year	5 (31.3%)
Not applicable	2 (12.5%)

[a]Of the 10 participants who reported a lifetime history of homelessness.

Qualitative Themes

We identified three themes describing beliefs and cultural practices that seemed to be protective against suicide among AAW Veterans. Some of these themes included subthemes. The first theme (resilience) included subthemes of learning resilience from the following: (a) experiencing adversity and (b) family. The second theme (social support) comprised informal social support networks and included reliance on family and friends. The third theme (religion) involved religious involvement and comprised three subthemes: (a) faith in God, (b) personal practices, and (c) religious beliefs. Of note, themes and subthemes were interrelated. For example, religion may be referenced in the description of social support. Qualitative themes and associated quotes are described in more detail below. Participant information, including select quotes, has been de-identified to protect confidentiality.

Theme 1: Resilience. Resilience emerged as a powerful theme. Women described developing resilience through two primary methods: overcoming adversity and through family.

Overcoming adversity. The theme of resilience by overcoming adversity was prevalent. Women described overcoming different challenges in their lives, and surviving and bouncing back from adverse experiences, such as military-related experiences, interpersonal violence (e.g., military sexual trauma, intimate partner violence, childhood abuse), homelessness, and drug addiction. One woman who was verbally and physically abused by her parents as a child stated,

> . . . Understand myself to know that I'm the best that I can be right now, and I'm not subjugated to be looked at less than . . . I just feel that I've just had a lot of hard living, not like with drugs or alcohol, just like a hard life.

Many described previously feeling life was not worth living following exposure to adverse life experiences, but none

Table 2. Military Characteristics (*N* = 16).

Characteristic	*n* (%) or *M* (*SD*)
Branch	
Army active duty	10 (62.5%)
Army reserves	1 (6.3%)
Army national guard	2 (12.5%)
Air force active duty	3 (18.8%)
Service era	
Post-Vietnam/peacetime	12 (75.0%)
Desert storm/shield	4 (25.0%)
Rank[a]	
E1	1 (6.3%)
E3	5 (31.3%)
E4	4 (25.0%)
E5	3 (18.8%)
E6	1 (6.3 %)
Officer	1 (6.3%)
Enlisted—not specified	1 (6.3%)
Deployment	
Deployed	4 (25.0%)
Not deployed	12 (75.0%)
Number of deployments[b]	1 (0)
Combat experience	
None	16 (100.0%)

[a]Ranks E1 to E6 are enlisted personnel.
[b]Of the four participants who reported a prior deployment.

described feeling that way in the present. For example, a woman who had faced challenges such as unemployment, homelessness, and previously attempted suicide explained,

> What doesn't kill you only makes you stronger. 'cuz I've been raped several times. And I dealt with a lot of sexual harassment during the military. Tons of it . . . I was resilient in getting through those times.

Women talked about hardships they faced due to their race and how these played a role in their development into "strong Black women." Despite facing adversity, the words participants used to talk about themselves described feelings of empowerment and a strong sense of being survivors. They mentioned waking up every day and continuing to live, despite these challenges. Overwhelmingly, participants described taking actions to improve their lives, and described focusing on the positive aspects of their lives, despite adversity. One woman who was permanently injured in an accident acknowledged, "I don't know if you realize one day that you are resilient. I think it's by continually overcoming obstacles . . . and having the hope and expectation that it will get better."

Family. Many participants indicated they learned to be resilient by their upbringing, most often through family, or by observing others. A woman who recently completed her doctoral degree explained,

> I looked at the people in our community . . . where you saw people who were so determined and so focused. And then you saw the other ones who, no matter what, they were still doing the same thing. And I didn't want to be at the end of that spectrum.

Another who was raised by her grandmother after her mother died declared, "Things happen and you just gotta keep going. So just watching [my grandmother]. And just knowing that, hey, I can get through it." Finally, another woman who reported having suicide ideation after a sexual assault, but never attempted suicide, shared, "My mother taught me nothing can be that bad to take my own life."

Theme 2: Social support. Women described strong social support systems comprising family and friends. A woman who was grieving the recent death of her mother stated, "I always talk to my dear friend. I talk to her a lot about things that's going on and how I feel . . . And she always reminds me what the Bible says . . . "

Nearly all women indicated if they were thinking about suicide they would get support from family and friends prior to seeking professional assistance (such as therapy). Overwhelmingly, when asked what would stop them from attempting suicide, the most prominent theme was the impact suicide would have on others—most notably, family. A woman who was married for many years and had several children described her responsibility to her family by stating the following:

> We tell our kids . . . that whatever is going on is just temporary, and suicide is final. That whatever the situation is . . . it's only going to last for a moment. But once I kill myself, there is no coming back from it. So that is definitely something that I would not, I can't entertain, because my kids would suffer from it. My family would suffer.

Participants consistently indicated family made their lives worth living. When specific family members were cited as reasons for living, children and grandchildren were often discussed. One woman, who stated she speaks with her mother on the phone daily, mentioned the importance of setting an example for younger generations. She stated, "I'm the youth pastor at my church now . . . When you have kids that look up to you, no matter what situation, you have to think about the examples you're setting for children."

Theme 3: Religion. Several subthemes comprised the final theme: (a) faith in God, (b) personal practices, and (c) religious beliefs.

Faith in God. The vast majority of women indicated religion played a substantial role in their lives, with several indicating it was their priority, describing it as "everything" or their "number one role." They described a strong sense of faith and indicated this helped to protect them from attempting suicide. This belief was poignantly captured by

a homeless woman who stated, " . . . 'God, my life is in your hands. Do with me what you will.' It's not in my hands to take my life. It's up to God . . . He knows the number of my days." This sentiment was affirmed by another participant who formerly abused drugs but at the time of the interview had been sober for several years:

> It doesn't matter even if I do want to die because if it's not my time, I'm not going to go. So I haven't had any more thoughts of suicide. I used to turn to drugs, but now I just . . . pray a lot, go to church, rely on my family.

Women also described the need to "see what God has for me" as being a past and future reason for living. Another woman stated,

> . . . Without God, I'd be dead right now . . . And without God in my life, knowing that I had power protecting me when I didn't even know it, you know? Somebody was praying for me . . . I thank God that he had mercy on my soul.

Finally, one participant with a history of multiple suicide attempts described how her relationship with God helped her to stay alive: "I keep telling myself that God loves me. And I'm somebody to him so I'm meant to live every day. I haven't always felt that way."

Personal practices. Many women indicated religious practices, particularly prayer, helped them cope with daily challenges and survive. Several women mentioned the benefits of prayer as a first line of defense. One woman who was sexually assaulted while in the military remarked, "If we didn't pray about all the different situations in our life, yeah, we'd probably be doing a lot of therapy." A woman who had never attempted suicide expressed what actions she would take if she began to have thoughts of killing herself: "I'd pray first. Then I would call somebody." A survivor of domestic violence explained, "Pray. Because sometimes that's all you have."

Women also described using prayer to keep feeling good about themselves when challenged. They mentioned the prosocial impact of religion and prayer, emphasizing how it helped them to help others. The potential long-term effects of prayer were captured by a survivor of cancer who stated, "I can pray to God and get peace and joy and then, when I read my Bible, I feel happy."

Religious beliefs. Most participants reported having negative perceptions of suicide, including the belief that suicide was "not an option" for them. Many provided detailed descriptions of experiences, beliefs, and cultural practices that had shaped such beliefs. One woman who reported being "raised on the streets" shared, "The Bible basically states, you know, I can't quote it, but basically what it sayin' is suicide is for a wimp."

Discussion

The results of this study provide initial support for the salience of specific cultural beliefs and practices buffering against suicide risk among AAW Veterans. Our research identified religiosity, social support, and resilience as important protective factors. The prominence of different aspects of religion (i.e., faith in God, personal practices, and religious beliefs) for AAW Veterans suggest that such components are likely important in protecting against suicidal thoughts and behaviors, at least among the women interviewed.

Our finding that religiosity was an important protective factor against suicide is consistent with prior theories that suggested African Americans have strong convictions against suicide due to religious beliefs (Early & Akers, 1993; Gibbs, 1997; Molock et al., 2006). Many participants emphasized the importance of reading the Bible and praying, which seemed to provide a sense of agency and calm. Women also noted how religion and social support served as coping strategies to buffer suicide risk. The fact that participants consistently mentioned protective factors characteristic of African American culture is consistent with findings that have emphasized the importance of cultural manifestations of suicidal behavior (Canetto & Lester, 1998; Carrington, 2006; Chu et al., 2013; Range et al., 1999).

Historically, African Americans have been denied access to formal services, such as Social Security, welfare, and housing subsides (Gray & Keith, 2003). Institutional and racial discrimination can make it challenging for African Americans to rely on anyone outside of the African American community. Consequently, when crises and emergency situations occur, African Americans have learned to depend on informal assistance from family, friends, church members, and organizational memberships (Gordon, 1994; Gray & Keith, 2003; Quadagno, 1994; Taylor, Hardison, & Chatters, 1996).

Many of the themes produced solidified the notion that AAW consider themselves to be the backbones of their families (Collins, 2006)—for example, reporting they would not attempt suicide due to the detrimental impact it would have on younger family members. Although this may not be unique to this racial group, there were unique ways in which AAW described their responsibility to their families. For example, many women described family as a significant reason for living to set an example for subsequent generations.

Despite the emphasis on family, there did not appear to be an awareness of the African American community. Though participants talked about community, they did not seem to identify with the African American or Veteran/military community. When asked to describe their community, women seemed unsure of what the question meant. Also worth noting, none identified as a Veteran when describing their identity.

Strengths of the current study include the use of qualitative data, which resulted in an informative description of cultural beliefs and practices among AAW Veterans. AAW Veterans were eager to share their experiences. Snowball

sampling was successful, as Veterans came in to participate in the study and often returned with their friends or referred them through warm handoffs.

This study is not without limitations. First, our study relied on interviews, which could be negatively affected by response bias. Second, our sample is likely not representative of AAW Veterans as a whole. For example, none of our participants had served in the post-9/11 conflicts, and none reported combat exposure. Although snowball sampling facilitated recruiting, a possible by-product was participants were demographically similar to one another. For example, several reported their sexual orientation as gay, lesbian, or queer ($n = 4$), bisexual ($n = 1$), or other ($n = 1$), described a history of substance use, and the mean age was 53.3 years. Such demographic features and the geographic location of the study limit the generalizability of our findings to other groups of AAW Veterans. Despite these limitations, our findings provide important information about cultural beliefs and practices that may serve as protective factors against suicide, and provide knowledge on protective factors by considering the influential role of culture.

The goal of this research was not to identify suicide risk factors; however, when asked about resilience, participants described challenges they faced and identified how they became resilient. These findings highlight the presence of both risk and protective factors, such as trauma exposure (a risk factor) and resilience (a protective factor). Thus, a logical next step for future research would be to quantitatively confirm whether the themes identified in this study protect against suicidal SDV in a larger sample of AAW Veterans recruited within and outside formal organizations such as the VA. In addition, future research examining perceptions of suicide could be a key factor in the development of culturally sensitive models of coping among AAW Veterans. Another suggestion for future research is to take an intersectional approach that explores the interplay between gender, culture, and class, which would acknowledge the tremendous diversity that may exist among AAW Veterans. Studies on the impact of social class on one's decision to join the military or importance of religion are also needed and could examine how these relate to the themes identified in the present study.

Implications for Practice and/or Policy

Our findings emphasize several important considerations for practitioners and policy makers. Although AAW Veterans may report historical experiences (such as military sexual trauma or childhood abuse) established as suicide risk factors in other cohorts (Dube et al., 2001; Kimerling, Makin-Byrd, Louzon, Ignacio, & McCarthy, 2016), clinicians should further assess how such experiences have affected them. In our study, women not only described such experiences as the most difficult they experienced in their lifetimes but also often reported that they became stronger and developed resilience as a result. Thus, their constellation of suicide risk and protective factors may be complex and likely may change over time. In addition, many women described social support networks comprising family and friends as integral to preventing them from thinking about or acting on thoughts of suicide. Notably, more indicated that they would utilize such informal support systems or rely upon religiosity (e.g., prayer, faith), rather than utilizing formal support mechanisms (e.g., mental health care). Thus, policy makers should be aware that suicide prevention efforts for AAW Veterans may be more effective if targeted within religious communities and via existing support networks. Finally, considering that AAW Veterans in our sample reported many aspects of religiosity as being protective against SDV, being familiar with how these different aspects of religion (i.e., practices, beliefs, and faith) may serve as protective factors for AAW Veterans may help clinicians to work collaboratively with their clients in understanding factors that protect against suicidality (e.g., when creating a Safety Plan; Stanley, Brown, Karlin, Kemp, & VonBergen, 2008).

Conclusion

The suicide rate among AAW is the lowest of all racial and gender groups (Centers for Disease Control, 2014), which may explain why they have received such limited attention from suicidologists. Limiting suicide research to groups at higher risk (such as Caucasian men), though important, likely provides a limited perspective that fails to acknowledge cultural and social determinants of health. "There are specific historical and cultural circumstances and lived experiences unique to each racial and gender group, and these differentially shape factors that increase or decrease vulnerability and resilience" (Nauert, 2015, para. 17). However, the protective features of cultural beliefs and practices among AAW Veterans should not be dismissed as only applicable to that population. It is possible that what is found to be protective for AAW Veterans may buffer against suicide risk in other populations as well, irrespective of race or gender.

Appendix

Semistructured Interview Questions

Identity

1. How would you describe your identity?
2. What is it like to be an African American female Veteran?

Values

3. What is important to you? What are your values?

Community

4. What does your community look like?
5. What are your perception(s) of the African American female Veteran community?

Challenges

6. What are the most significant challenges you have faced?

Coping

7. How have you coped with these challenges?

Resilience

8. How do you keep feeling good about yourself when challenges occur?
9. What have you done that demonstrates resilience?
10. How did you become resilient?

Social supports

11. Please describe your social support system.

Religion

12. What role, if any, does religion or spirituality play in your life?

Lifetime suicidal ideation and suicide attempt

13. Sometimes people feel that life is not worth living. Can you tell me how you feel about your own life?
14. Have there been any times in your life when you thought about suicide (i.e., killing yourself)?
15. Have you ever attempted to kill yourself?
16. What was going on in your life at the time that caused you to think about suicide and/or attempt suicide? (*modify based on response to Question* 14)

Deterrents to suicide/reasons for living

17. If you began to have thoughts of killing yourself, what would you do to cope with those thoughts?
18. If you were thinking about killing yourself, what would presently stop you from attempting suicide?
19. What aspects of your life make it worth living?

Authors' Note

The views expressed are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs or the U.S. Government.

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